This manual was developed for use by KCCRT/Disaster Outreach Personnel for early phase response to a terrorist or mass-trauma event - helping individuals and communities heal by fostering resiliency.

KCCRT
ALL HAZARDS
Field Manual

Disaster Outreach Personnel includes: behavioral health professionals, peer professionals or para-professionals; trained victim advocate; adults from communities who possess cultural, multilingual skills or life experiences necessary to identify and communicate with survivors and victims; or support personnel necessary in providing disaster and crisis intervention services; and approved by the Board to provide disaster behavioral health services and trained to alleviate the pain and distress of affected groups and individuals during a response effort, but are not a licensed or credentialed behavioral health provider.

Disaster/Mass-Trauma Event

means an occurrence, regardless of cause, such as a hurricane, tornado, flood, earthquake, explosion, hazardous materials accident, war, transportation accident, mass shooting, fire, famine, or epidemic that causes: (a) Human suffering; or (b) Creates collective human need that requires outside assistance to alleviate; or (c) Means an incident or situation declared as such by executive order of the Governor, or President of the United States, pursuant to federal law; and (d) Is of sufficient severity and magnitude to warrant disaster assistance to supplement the resources of States, local governments and disaster relief organizations in alleviating damage, loss, hardship and suffering.

Terrorism

The basic law of terrorism is that even the smallest threat can ripple out to touch people a thousand miles away. The basic goal of psychological interventions is to understand the traumatic impact of terrorism and to use that understanding to minimize and contain the ripple effect within the individual, community, and our nation.

—American Psychological Association Report on the Oklahoma City Bombing, 1997

What makes an act of terrorism so very different from a natural disaster is the intent behind it—to harm, kill, and scare defenseless people to deliver a message for political, religious, or sociocultural purposes. Coping with these acts can set off a chain of psychological events culminating in feelings of fear, anger, helplessness, vulnerability, and grief.

Terrorism has been defined, as follows:

An activity that involves a violent act or an act of dangerousness to human life that is in violation of the criminal laws of the United States, or of any State … and that appears to be intended to intimidate or coerce a civilian population … or to influence the policy of government by assassination or kidnapping.

—Department of Justice [18 U.S.C. 3077]

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24-Hour Response Request Line
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Some material for this manual has been utilized and edited from the following resource:

HELPING TO HEAL: A Training on Mental Health Response to Terrorism Field Guide. Prepared by: Community Resilience Project of Northern Virginia Commonwealth of Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, January 2004

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APPENDIX

INTRODUCTION

The Role of KCCRT/Disaster Outreach Personnel


Photo: Southern Heart

The role of KCCRT/Disaster Outreach Personnel as well as the location and types of services that will be offered after a mass-trauma or terrorism event are defined by the type and impact of the event. These events may move some KCCRT/Disaster Outreach Personnel to the role of a first responder. The behavioral health response to mass-trauma or terrorism is community-based and may include direct and indirect services. Services may be provided **directly** in family service centers where family members find out the status of their loved ones, at the site, and at various locations throughout the community. **Indirect** services may involve staffing hotlines, disseminating self-care and peer-care information to support organizational/command identified needs as they evolve.

KCCRT/Disaster Outreach Personnel may partner with organizations that provide for basic needs such as water, food, clothing and other necessary supplies for the first responders and survivors at designated sites or in a family service center. During the immediate phase, the provision of addressing basic human needs and providing support is often what is most needed. This provides KCCRT/Disaster Outreach Personnel the opportunity to do rapid assessment, provide psychological first aid (aka crisis intervention), outreach, and supportive participation in death notification.

Psychological First Aid means the application of three basic concepts of: protect, direct and connect. Includes: addressing immediate physical needs; comforting and consoling survivors, victims, first responders and others; providing concrete information about what will happen next, listening to and validating reactions; linking survivors to support systems; normalizing stress reactions to trauma and sudden loss; reinforcing positive coping skills; facilitating telling their story and supporting reality-based practical tasks.

The experience, training, and qualities that KCCRT/Disaster Outreach Personnel possess make them uniquely qualified to provide psychological first aid and supportive services immediately after mass-trauma or terrorist events. These qualities include flexibility, sensitivity, the ability to set and respect boundaries, and a commitment to helping people.

Regardless of the event, one thing that will be important is helping individuals and communities heal by building their resilience skills—their ability to recover from tragedy.

Personal Preparedness

In order for KCCRT/Disaster Outreach Personnel to be prepared to respond in a mass-trauma or terrorism event, personal and family preparedness is essential. When an emergency occurs, it is both natural and healthy to be concerned about the safety and well-being of our loved ones. Without that assurance, work can become secondary. KCCRT/Disaster Outreach Personnel are likely to be called on to fill any number of roles and may need to work extended hours for several days at a time. Therefore, it is important that each KCCRT/Disaster Outreach Personnel develop a personal emergency preparedness plan that includes:

- How to make contact with family and other loved ones during an emergency
- What each member of the family can do to help ensure his or her own safety and the safety of others

Below are some recommended steps for developing a personal emergency preparedness plan.

- ❑ Learn the immediate community's warning signals and notification systems. Each community has its own system, and warnings may range from sirens over loud speakers to messages broadcast on local radio and TV stations.
- ❑ If children are in the home, establish a plan for their care in the event that parents or other caregivers are called away to help.
- ❑ If there are older or disabled family members, make arrangements for taking care of their special needs.
- ❑ Make sure that the places where the family spends much of its time—such as work, school, and day care—all have disaster plans, and that practice drills are conducted on a regular basis.
- ❑ If there are pets in the home, establish a plan for their care. In addition, inquire about the availability of animal care after a disaster. Many shelters do not admit animals due to health regulations.

Family Emergency Preparedness Plan

Without knowing what kind of event will occur and what kind of resources will be needed, personal preparedness may seem like an impossible task. That is why it is so important to develop and put plans into place now, before an event.

Planning is not that difficult, and it is very important. The following checklist is a guide for the family's emergency preparedness planning efforts.

- ❑ Meet to discuss why and how to prepare for a disaster.
- ❑ Discuss each type of disaster that could affect the family and how to respond.
- ❑ Make a map of the house and identify two escape routes from each room.
- ❑ Identify two meeting places, one inside the neighborhood and one outside, in case the family is separated and cannot return home. Make sure all family members have the addresses and phone numbers of these meeting places and keep this information on their person at all times.
- ❑ Identify an out-of-state family member or friend to be the family contact. Depending on where family members are at the time of the event, it may not be possible to reunite. It may be easier to make a long distance call than a local one, however, an out-of-state family contact can help coordinate communication among loved ones during a crisis. Make sure that all family members have the phone number of the contact person with them at all times, and, in the event of an emergency, know to call this person to tell them their location. Make sure to inform that person that family members will be calling him or her in case of an emergency.
- ❑ Post a list of emergency phone numbers by each telephone in the house. Include numbers for the fire department, police, an ambulance service, the family contact, family pagers and cell phones, neighbors, workplace contacts, schools and day care centers, and other important contacts. Ask family members to keep a copy of this list in their wallets or purses.
- ❑ Identify backup communications systems. On 9/11, telephone and other communications lines were jammed. Recognize that phone lines may be down, and other communications systems may be more appropriate, such as e-mail, pagers, personal digital assistants, etc.
- ❑ Instruct children about how to make a long distance call. This is particularly important if long distance numbers are included on the family's emergency contact list.
- ❑ Ensure at least two ways of contacting each other during an emergency. Since phone lines may be down or jammed, consider e-mail or text messaging as alternate modes of communication.
- ❑ Teach children how and when to call 9-1-1 for help. If the family resides in a rural area that does not use 9-1-1, make sure children know how to dial the local emergency medical service.
- ❑ Show each family member how and when to turn off the utilities (e.g., water, gas, electricity) at the main switch. Although this may seem extreme, remember that an adult may not be home at the time of the emergency, and children may need to protect themselves from a gas leak or other hazard.
- ❑ Show each family member where the fire extinguishers are kept and how to use them in an emergency.
- ❑ Install and regularly test smoke detectors on each level of the house, especially near the bedrooms. To ensure that detectors are in working order and that batteries are charged, conduct a test of all smoke detectors in the house on the first of every month.
- ❑ Take a first aid and CPR class.
- ❑ Store family records in a water- and fire-proof safe. Include birth and marriage certificates, social security cards, insurance policies, bank records, stock and bond certificates, wills, deeds or leases, and other important documents. Since the home may be damaged, make a list of all-important household possessions for insurance purposes, including model and serial numbers. Consider taking photos or videotaping belongings as well. Store another copy of the records in a safe-deposit box or another secure location away from home.
- ❑ Stock and regularly maintain a family preparedness kit. Make sure to replace stored water every three months and food every six months (see checklist below for recommended contents).

Posting the family emergency preparedness plan on the refrigerator at home and conducting regular practice drills with family members will help to increase their comfort level and confidence in their ability to respond. Having a different member of the family "manage" the drill each time can ensure that everyone is comfortable and can make it a family activity. It is a good idea for family members to carry some sort of identification on their person at all times.

Family Preparedness Kit

KCCRT/Disaster Outreach Personnel may consider having a large duffle bag or plastic container to hold many of the items for their preparedness kits to facilitate access and transport. As KCCRT/Disaster Outreach Personnel may be out in the field for long periods, they may want to keep another less comprehensive preparedness kit for personal use in a backpack in the car or office. Below are suggestions for items to include in a family preparedness kit.

The Basics

- ❑ Water, at least one gallon per person per day, for three to seven days
- ❑ Foods that do not require refrigeration or cooking, such as peanut butter and granola bars, at least enough for three to seven days
- ❑ At least one flashlight with plenty of extra batteries
- ❑ A battery-powered radio with extra batteries
- ❑ A first aid kit, including a supply of all prescription medications currently taken by family members in their original bottles, plus copies of the prescriptions and any other important medical information, such as physicians' contact information
- ❑ Eyeglasses, with a copy of the prescription
- ❑ Plastic garbage bags, ties, and toilet paper for personal sanitation
- ❑ Feminine supplies
- ❑ A plastic bucket with tight lid
- ❑ Moist hand wipes
- ❑ Cash, including coins, as ATMs and banks may not be open or available
- ❑ A map of the area, to identify evacuation routes and locate shelters
- ❑ Special items that small children and the elderly might require
- ❑ Toys, books, and games
- ❑ Nonperishable food for pets

Clothing and Bedding

- ❑ At least one change of clothes, including shoes, for each family member (both warm and cold weather clothes if the area is affected by the seasons)
- ❑ Pillows and either sleeping bags or warm blankets for each family member

Tools

- ❑ A first aid book
- ❑ A signal flare and compass
- ❑ Mess kits or plastic utensils and paper cups and plates
- ❑ A non-electric can opener
- ❑ A utility knife
- ❑ A small fire extinguisher
- ❑ Matches in a waterproof container
- ❑ Paper towels
- ❑ Aluminum foil and plastic storage containers
- ❑ Paper and pencils or pens
- ❑ Pliers and a shut-off wrench, to turn off household gas and water (if necessary)
- ❑ Regular household bleach and a medicine dropper, to purify water in an emergency (Use 16 drops per gallon of water.)
- ❑ Plastic sheeting and duct tape
- ❑ A tube tent (i.e., a simple survival tent)

Kentucky Disaster Response & Terrorism Preparedness History

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) is the State Mental Health Authority (SMHA). Kentucky's public behavioral health system is organized into fourteen (14) geographic regions for the purposes of planning and providing mental health, mental retardation, and substance abuse services. The mental health/mental retardation boards (also known as community mental health centers) are private, non-profit organizations mandated by state statute (KRS 210.370-210.480) as independent non-state agencies. Together they serve all 120 counties. The centers are mandated by state law to provide the following: inpatient services, outpatient services, partial hospitalization/psychosocial rehabilitation, emergency services, consultation and education, mental retardation services and substance abuse services. Centers also actively provide supportive and rehabilitative services such as case management, housing support, and respite services that enable persons to live in the community. These private entities described above are not funded for the delivery of disaster behavioral health services.

In the past, KDMHMRS has worked along with fourteen (14) Community Mental Health and Mental Retardation Centers to mitigate the effects of disasters. Kentucky, unfortunately, experienced many disasters that demonstrated a clear need for an organized behavioral health response to community-wide crises. In the 1990's the state's efforts to provide such responses evolved into the Kentucky Community Crisis Response Board (KCCRB), a unique agency that was developed and established by the SMHA. During the evolution of KCCRB, a conscious choice was made to administratively attach the KCCRB to state government, where it could best work with other organizations and agencies to mitigate the effects of natural and person-made disasters. The Kentucky Department of Military Affairs was chosen because it also has purview over the National Guard, the Emergency Operations Center and the KY Division of Emergency Management. The KCCRB was legislatively defined in Kentucky statute (KRS 36.250 to 36.270) in 1996 and administratively attached to Military Affairs in 1998.

As the Mental Health Authority, KDMHMRS staff have served in the role of Disaster Mental Health Coordinators and worked with the KCCRB and the Governor's Authorized Representative (GAR) to submit Federal Emergency Management Agency (FEMA) crisis counseling grants. The KCCRB, which is comprised of all agencies in the Commonwealth involved in disaster response, recommended that the KCCRB become the lead state agency designated to coordinate disaster behavioral health services and to submit FEMA crisis counseling grant applications.

When a disaster strikes, the KCCRB is activated through Kentucky's Emergency Operations Center and plans in collaboration with local Fire and Police Departments, local, regional and state Emergency Management, regional mental health centers and the American Red Cross. KCCRB mobilizes disaster behavioral health activities post disaster through its network of team members, mental health centers in the impacted region, and other behavioral health service delivery systems through mutual aid agreements. KCCRB complies with the National Incident Management System (NIMS) protocols through the Kentucky Department of Emergency Management.

KCCRB responded to 14 presidential-declared disasters, provided immediate disaster response, applied for FEMA crisis counseling grants and provided administrative and training support to Project Recovery from the floods of 1997 to May 2005.

KCCRB, as the state lead disaster behavioral health agency, procures and administers FEMA Immediate and Regular Services crisis counseling grant applications on behalf of the survivors of disasters across the Commonwealth of Kentucky.

KCCRB secured 100% federally funded FEMA grants of $1,454,535.87 for crisis counseling outreach services for storms which produced damaging winds, heavy rainfall, tornadoes, mudslides, hail, flash flooding and floods in eastern and central portions of the state in May 2004.

Project Recovery-FEMA 1523 Immediate Services Program (May 2004-September 2004) served 12,480 survivors through individual crisis counseling, brief contacts, and presentations to schools, health care clinics, agency networks, and other local and regional social service agencies. KCCRB, Pathways, Kentucky River, and Seven Counties provided outreach services to survivors.

Project Recovery-FEMA 1523 Regular Services Program (September 2004-May 2005) has served 44,633 survivors through individual crisis counseling, brief contacts, and presentations to schools, health care clinics, agency networks, and other local and regional social service agencies. KCCRB, Pathways, and Kentucky River provided outreach services to survivors.

KCCRB's State Level Grant Manager was invited to submit an article to SAMHSA DTAC on reflections of FEMA 1523 RSG. The article is published in The Dialogue, an online quarterly information bulletin providing time sensitive, practical, and down-to-earth information for State and Territory mental health and substance abuse coordinators and their local service providers (Article is located at: http://www.mentalhealth.samhsa.gov/dtac/).

Project Recovery management designed a customer satisfaction survey utilizing technical assistance from SAMHSA Disaster Technical Assistance Center (DTAC) staff. The goal of the survey was to gain survivors' perception of Project Recovery in terms of service delivery, symptom reduction, and service support. A sample of 100 disaster survivors was randomly selected 6 months after the disaster. Surveys were conducted over the telephone and took approximately 10-30 minutes to complete. Survey results in eastern Kentucky show a consumer is most likely to be 26-30 years of age, female, and Caucasian. Most frequently consumers will report being hyper-vigilant, watchful, worried, fatigued, and anxious. These areas will be important to assess and focus on in future disasters. Survey results indicate that providers will need to focus primarily on strategies that ease emotional stress.

Disaster & Terrorism Preparedness Training

KCCRB, for the third consecutive year, received $200,000 Bioterrorism Grant from the Kentucky Department for Public Health (DP)/ CDC for response readiness in terrorism and disasters. As a major deliverable, KCCRB developed in collaboration with the Kentucky Department for Public Health (DPH), a course designed to teach the definitions and psychological effects of disaster and terrorism. The PDT course covers topics including understanding the need for psychological first aid after a disaster or terrorist event, knowledge of common stress reactions, understanding basic principles of early interventions and risk communications, understanding the purpose and use of Information Briefings (IB). This course is also designed to give an overview of Weapons of Mass Destruction (WMD) and expected psychological reactions to such weapons. The course has been approved to offer CEU's for CADC, KPA, LMFT, Nursing, EILA, and Social Work.

Working In a Disaster Environment

Disaster & Terrorism: Immediate Crisis Intervention

Goals and Priorities

During and immediately following a mass-trauma incident, those most impacted may experience shock, confusion, fear, numbness, panic, anxiety, distancing and "shutting down." Witnessing or suspecting the deaths of friends or family members can be emotionally overwhelming. Survivors who are not physically injured may be taken to separate sites to be interviewed as witnesses and to be connected with loved ones. Those with injuries are taken quickly to area hospitals. When the perpetrators have not been apprehended or the event is considered to be terrorism, all experience a sense of continued danger and threat. KCCRT/Disaster Outreach Personnel have four initial, immediate intervention goals: (1) identify those in need of immediate medical attention for stress reactions; (2) provide supportive assistance and protection from further harm; (3) facilitate connecting survivors with family and friends; and (4) connect survivors with designated officials responsible for dissemination of information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts.

During this phase of the response, emotional stabilization is the primary objective. Because an overriding response of many crime victims is to feel vulnerable and fearful, interventions emphasize protection, safety, and promotion of a sense of security.

Acute response shock and confusion gradually give way to increasing awareness and understanding of what has occurred and the related personal consequences. Those most affected and their loved ones may be in hospitals, gathered at sites awaiting critical information, searching for missing loved ones, or in their homes. If homes and buildings were destroyed, those displaced may be in shelters, at alternate care facilities, staying in hotels, or in the homes of friends and family.

KCCRT/Disaster Outreach Personnel coordinators must quickly determine those groups most affected and the best ways to reach them. Assuming that the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, intervention goals follow:

- Alleviate distress through supportive listening, providing comfort, and empathy;
- Facilitate effective problem-solving of immediate concerns;
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor; and
- Provide psycho-educational information regarding post-trauma reactions and coping strategies.

Conducting an Onsite Assessment

KCCRT/Disaster Outreach Personnel providing psychological first aid/disaster behavioral health services would typically be deployed to the following sites: shelters; meal sites; respite centers; disaster recovery centers and service centers; family assistance centers; lines, roadblocks; first aid stations, hospitals; schools; community centers; places of worship; memorials; police and fire departments; emergency operation centers, incident command centers; and neighborhoods. These assignments would be coordinated through the KCCRT Response Coordinator(s). Usual and customary work shifts are 8-12 hours.

Upon arrival at the site, the KCCRT/Disaster Outreach Personnel will report to KCCRT Response Coordinator, whose immediate task will include onsite needs assessment, assigning assessment teams, setting priorities, assessing the environment, survivors, and workers; triaging for needed services, and conducting interventions. The importance of conducting a thorough and thoughtful onsite assessment is critical to the immediate and long-term behavioral health of those affected.

Rapid onsite assessment is conducted through the use of **Psychological First Aid.** Psychological first aid is the application of three basic concepts of: protect, direct and connect. It includes: addressing immediate physical needs; comforting and consoling survivors, victims, first responders and others; providing concrete information about what will happen next, listening to and validating feelings; linking survivors to support systems; normalizing stress reactions to trauma and sudden loss; reinforcing positive coping skills; facilitating telling their story and supporting reality-based practical tasks.

One-on-one brief conversation (SAFE-R or 4-Step Guide to Conversation models) are interventions conducted in onsite assessment. Because these sites will likely be somewhat chaotic, brief conversation as a method of onsite assessment will probably consist of short conversations in passing, perhaps in line for coffee or while eating. Psychological first aid allows the KCCRT/Disaster Outreach Personnel to quickly "work the room" and assess which survivors, responders, or others might need additional support, reassurance, or information. It also provides the opportunity to assess and refer those who might need more in-depth services. Finding unobtrusive ways to be in the vicinity of survivors and responders, such as handing out blankets or offering to get someone a soft drink, can help facilitate this process.

Provide support and reassurance through reflective listening, dispensing information, and offering practical help throughout the interaction. As the KCCRT/Disaster Outreach Personnel moves to closure of the interaction, it is important to assess the survivor's support system to determine if a referral for further services is necessary. If a strong support system exists, emphasize the value that such social support can have in the recovery process. In addition, helping survivors recall their successful coping strategies in previously stressful experiences is also enormously helpful.

Incident Command

In a Mass-Trauma Disaster and Terrorist Event Environment

To provide standards for domestic incident response, President Bush signed Homeland Security Presidential Directive-5. HSPD-5 authorized the Secretary of Homeland Security to develop the National Incident Management System, or NIMS. NIMS provides for interoperability and compatibility among all responders.

NIMS Concepts and Principles

- NIMS provides a framework for interoperability and compatibility by balancing flexibility and standardization.
- NIMS provides a flexible framework that facilitates government and private entities at all levels working together to manage domestic incidents. This flexibility applies to all phases of incident management, regardless of cause, size, location, or complexity.

NIMS Components

NIMS is comprised of several components that work together as a system to provide a national framework for preparing for, preventing, responding to, and recovering from domestic incidents. These components include:

- Command and management.
- Preparedness.
- Resource management.
- Communications and information management.
- Supporting technologies.
- Ongoing management and maintenance.

Although these systems are evolving, much is in place now.

Incident Command System (ICS)

NIMS requires that responses to all domestic incidents utilize a common management structure. The Incident Command System (ICS) is a standard, on-scene, all-hazard incident management concept.

ICS is a proven system that is used widely for incident management by firefighters, rescuers, emergency medical teams, and hazardous materials teams. ICS represents organizational “best practices” and has become the standard for incident management across the country.

ICS is interdisciplinary and organizationally flexible to meet the needs of incidents of any kind, size, or level of complexity. Using ICS, personnel from a variety of agencies can meld rapidly into a common management structure.

ICS Features

ICS has several features that make it well suited to managing incidents. These features include:

- Common terminology.
    - ICS requires the use of common terminology, including standard titles for facilities and positions within the organization.
    - It also include utilizing “clear text” communications (plain English)
- Organizational resources.
    - Resources, including all personnel, facilities, and major equipment and supply items used to support incident management activities, are assigned common designations.
- Manageable span of control.
    - Effective span of control may vary from three (3) to seven (7), and a ratio of one (1) supervisor to five (5) reporting elements is recommended.
- Organizational facilities.
    - The Incident Command Post
    - One or more staging areas.
    - A base.

- One or more camps (when needed).
- A helibase.
- One or more helispots.

- Use of position titles.
  - Only the Incident Commander is called Commander – there is only one Incident Commander per incident.
  - Only the heads of Sections are called Chiefs.
- Reliance on an Incident Action Plan.
  - Incident Action Plans (IAPs) provide a coherent means to communicate the overall incident objectives in the context of both operational and support activities. IAPs are developed for operation periods that are usually 12 hours long.
  - IAPs depend on management by objectives to accomplish response tactics. These objectives are communicated throughout the organization and are used to:
    - Develop and issue assignments, plans, procedures, and protocols.
    - Direct efforts to attain the objectives in support of defined strategic objectives.
  - Results are always documented and fed back into planning for the next operational period.
- Accountability.
  - Effective accountability at all jurisdictional levels and within individual functional areas during an incident is essential. To that end, ICS requires:
    - An orderly chain of command-the line of authority within the ranks of the incident organization.
    - Check-in for all responders, regardless of agency affiliation.
    - Each individual involved in incident operations to be assigned only one supervisor (also called "unity of command").

Unified Command

Unified Command is an application of ICS when:

- There is more than one responding agency with responsibility for the incident.
- Incidents cross-political jurisdictions.

Under a Unified Command, agencies work together through the designated members of the Unified Command to:

- Analyze intelligence information.
- Establish a common set of objectives and strategies for a single Incident Action Plan.

Unified Command does not change any of the other features of ICS. It merely allows all agencies with responsibility for the incident to participate in the decision-making process.

Area Command

An Area Command is an organization established to:

- Oversee the management of multiple incidents that are each being managed by an ICS organization.
- Oversee the management of large incidents that cross-jurisdictional boundaries.

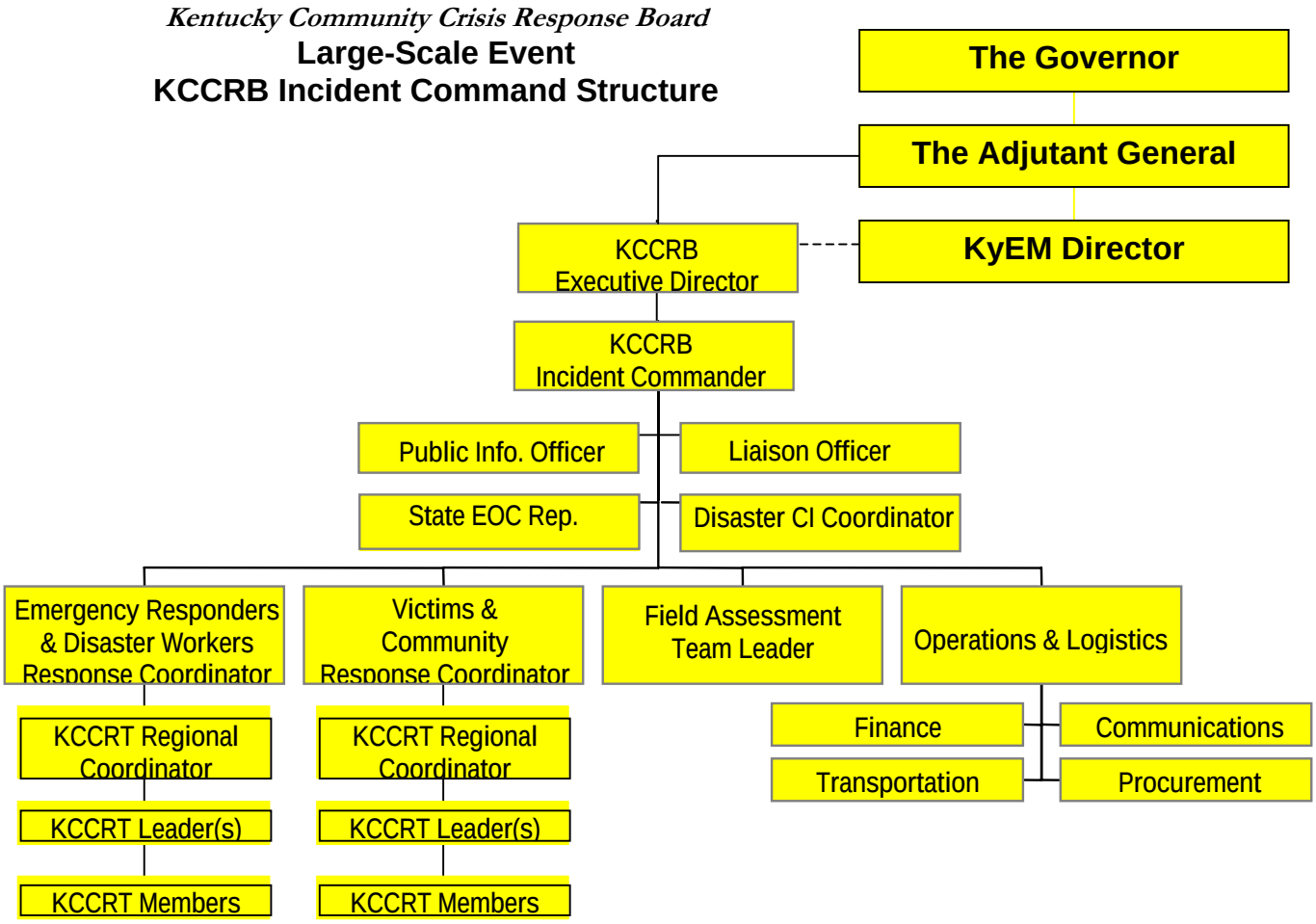
Multiagency Coordination System

On large or wide-scale emergencies that require higher-level resource management or information management, a Multiagency Coordination System may be required. It would include Emergency Operations Centers (EOCs) and, in certain incidents, Multiagency Coordination Entities.

For more information on these components and features, see FEMA IS-700 NIMS Course at fema.gov, NIMS Integration Center. KCCRT Members will be given 4 hours of continuing education credit for providing proof of successful completion of this course.

KCCRB INCIDENT COMMAND

As agency under the Kentucky Department of Military Affairs, and as an active preparedness, response and recovery agency, KCCRB utilizes the Incident Command System (ICS) and will follow the protocol of the National Incident Management System (NIMS).



Agencies Active in Mass-trauma Disaster and Terrorist Events

It is important to be aware of the other responders who may be present onsite. Some will perform very specific tasks, such as searching for survivors, driving ambulances, or directing traffic. Others will provide more general assistance, such as calming crowds and handing out supplies. The following table provides an idea of who those other service providers might be.

Table 1. Who Might Be Found Onsite

Local Response Public Agencies	• Fire and rescue department • Law enforcement • Local emergency management • Public works • Emergency medical services • Hospitals • Local officials • County Coroners • Survivor services • Human services
Local Response Private Agencies and Civilians	• American Red Cross • Salvation Army • Unmet Needs Committee • Community action groups • Good Samaritans • Clergy • Media • Employee assistance programs • Funeral homes
State Response	• State emergency management • KCCRB • State medical examiner's office • Public works • National Guard • State police • Public health • Governor's office • State attorney's office • State crime survivor compensation program • Consumer Protection Agency
*Federal Response	• Federal Bureau of Investigation (FBI) • Bureau of Alcohol, Tobacco, and Firearms (ATF) • Office for Victims of Crime (OVC) • Federal Emergency Management Agency (FEMA) • Public Health Service (PHS) • Centers for Disease Control and Prevention (CDC) • Center for Mental Health Services (CMHS) • General Services Administration (GSA) • Small Business Administration (SBA) • Department of Veterans Affairs (VA)

**Note that many agencies are from a larger unit. CMHS and PHS, for example, are part of DHHS. Onsite, workers will probably identify themselves as being from CMHS or PHS, not DHHS.*

Range Of Reactions
And Appropriate Interventions And Services

Common Reactions to Trauma

Most people experience typical reactions to terrorism and traumatic events. It is critical to reassure survivors that their reactions are normal, regardless of how they may feel. The following chart organizes, by age, typical cognitive, behavioral, physical, and emotional reactions to traumatic events.

All Ages
- Anger
- Anxiety
- Appetite changes
- Colds or flu-like symptoms
- Concentration problems
- Fear of crowds or strangers
- Fear of darkness
- Feelings of hopelessness
- Guilt
- Headaches
- Mood-swings
- Nausea/stomach problems
- Nightmares
- Poor work performance
- Confusion
- Crying easily
- Denial
- Fatigue
- Fear of being left alone
- Hyperactivity
- Hyperviligence/increased watchfulness
- Increased drug and alcohol use
- Irritability
- Isolation
- Reluctance to leave home or loved ones
- Sadness
- Sensitivity to loud noises
- Sleep difficulties

Children of All Ages
- Anxiety and irritability
- Clinging, fear of strangers
- Fear of separation, being alone
- Head, stomach, or other aches
- Increased shyness or aggressiveness
- Nervousness about the future
- Regression to immature behavior
- Reluctance to go to school
- Sadness and crying
- Withdrawal
- Worry, nightmares

Preschool Age (1–5)
- Changes in eating habits
- Changes in sleeping habits
- Clinging to parent
- Disobedience
- Fear of animals, the dark, “monsters”
- Hyperactivity
- Speech difficulties
- Regression to earlier behavior (thumb sucking, bedwetting)

Early Childhood (5–11)
- Increased aggressiveness
- Changes in eating/sleeping habits
- Difficulty concentrating
- Regression to earlier behavior
- Competing more for the attention of parents
- Fear of going to school, the dark, “monsters”
- Drop in school performance
- Desire to sleep with parents

Adolescence (12–14)
- Abandonment of chores, schoolwork, and other responsibilities previously handled
- Disruptiveness at home or in the classroom
- Experimentation with high-risk behaviors such as drinking or drug abuse
- Vigorous competition for attention from parents and teachers
- Resisting authority

Problematic Reactions

The following may indicate the need for more extensive intervention and counseling:

- Disorientation—dazed; memory loss; inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening
- Inability to care for self—not eating, bathing, or changing clothes; inability to manage activities of daily living
- Suicidal or homicidal thoughts or plans
- Problematic use of alcohol or drugs
- Domestic violence, child abuse, or elder abuse
- Any common reaction may require intervention if it interferes with daily functioning

Risk Factors for Problematic Reactions to Trauma[1]

The following are risk factors at different stages of a terrorist event that may help identify individuals and groups who are more susceptible to having a more problematic stress response. Additional, immediate outreach and intervention efforts may be needed in these situations.

Personal Risk Factors Before Trauma

- Past history of Posttraumatic Stress Disorder (PSTD)
- History of childhood abuse
- Early attachment issues
- Family history of trauma
- Psychological difficulties
- History of substance abuse
- Female gender
- Younger age
- Low socioeconomic status
- Lower intelligence

Personal Risk Factors During Trauma and 24 Hours After Trauma

- Degree and intensity of exposure
- Dissociation
- Intrusion and avoidance
- Depression
- Hyper arousal
- Negative self-talk
- Lack of immediate social support

Personal Risk Factors After Trauma

- Lack of societal acknowledgment
- Lack of ongoing social support
- Stressful life events
- Unproductive family patterns

Dynamics of Symptoms Over Time

Post-event traumatic reactions may be:

- Intense or mild
- Immediate or delayed
- Cumulative in intensity
- Reactivated by:
- Subsequent traumatic experiences
- Reminders of the event:
- Anniversaries
- Area or object associated with the event (e.g., planes, building)

Symptoms may also be activated by vicarious trauma, such as media exposure or contact with people involved in the terrorist event.

1 Adapted from presentations made by Dr. Rony Berger, Psy.D., at Natal Israel Trauma Center for Victims of Terror and War, on June 11 and 12, 2002.

Intervention Goals [2]

At the scene of a mass-trauma disaster or terrorist event, facilitating physical and emotional safety is the primary objective. A common response of many survivors is to feel highly vulnerable and fearful; therefore, interventions emphasize protection and safety as well as promote a sense of security.

The four initial intervention goals are:

- Identify those in need of immediate medical attention
- Provide supportive assistance and protection from harm
- Facilitate connecting survivors with family and friends
- Connect survivors with designated officials responsible for dissemination of information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts

Once safety is established, the following four intervention goals should be targeted:

- Alleviate distress through supportive listening, providing comfort, and empathy
- Facilitate effective problem-solving of immediate concerns
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor
- Provide psychoeducational information regarding post-trauma reactions and coping strategies

Overview of Interventions and Services

Immediately following a mass-trauma disaster or terrorist event, the primary objective of psychological first aid is to facilitate emotional stabilization. After the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, interventions should aim to alleviate distress and help with problem-solving and recovery. The following is a description of the services conducted by trained KCCRT/Disaster Outreach Personnel.

Psychological First Aid

Protocol: *KCCRT provide psychological first aid in two types of incidents:*

- *By invitation and deployment in the aftermath of a critical incident*
- *When activated by KCCRB in the aftermath of a mass-trauma disaster or terrorist event*

Disaster Outreach Personnel provide psychological first aid:

- *When activated by KCCRB in the aftermath of a mass-trauma disaster or terrorist event*

Psychological first aid is assessment and triage. It is accomplished through use of informal conversation. KCCRT/Disaster Outreach Personnel, the Team Leader, Regional Team Coordinator, Disaster Response Coordinator or KCCRB Incident Command does assessment throughout the response.

Rationale: Rapid assessment is conducted at the designated sites by trained KCCRT/Disaster Outreach Personnel to identify survivors who are most psychologically distressed and/or in need of medical attention. Initially, triage decisions are based on observable and apparent data. Persons experiencing physiological reactions such as shaking, screaming, or disorientation, may need to receive emergency medical attention. Psychological first aid involves three basic concepts: protect, direct, and connect. Its' application includes comforting the survivor, addressing immediate physical necessities, listening to and validating feelings and stories, and other immediate needs. [3]

Survivors need to be protected from viewing traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.

When disoriented or in shock, survivors need to be directed away from the trauma scene and danger, and into a safe and protected environment. A brief human connection with KCCRT/Disaster Outreach Personnel can help to orient and calm them.

KCCRT/Disaster Outreach Personnel assist survivors by connecting them with loved ones, as well as with needed information and resources.

2 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

3 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Crisis Intervention[4]

Protocol: *KCCRT/Disaster Outreach Personnel use either the SAFE-R Model or 4 Step Guide to Conversation as models for individual crisis intervention.*

Rationale: While crisis intervention is similar to psychological first aid, it goes beyond the first stages of the disaster to:

- Assist survivors to regain some sense of control and mastery over their immediate situations
- Reestablish rational problem-solving abilities

An underlying assumption is that the survivor's distress and coping difficulties are due to the suddenness, horror, and catastrophic nature of the event. Crisis intervention typically involves five components:

- Promoting safety and security (e.g., finding the survivor a comfortable place to sit, giving the survivor something to drink)
- Exploring the person's experience with the disaster (e.g., offering to talk about what happened, providing reassurance if the person is too traumatized to talk)
- Identifying current priority needs, problems, and possible solutions
- Assessing functioning and coping skills (e.g., asking how he or she is doing, making referrals if needed)
- Providing reassurance, normalization, psychoeducation, and practical assistance

Informational Briefings[5]

Protocol: *KCCRT/Disaster Outreach Personnel provide informational briefings on normal reactions to traumatic events as a type of group outreach when a formal group intervention is not appropriate. Authorized KCCRB/KCCRT/Disaster Outreach Personnel may work with officials in a large-scale event to provide guidance in addressing reactions. Pre-written handout materials are available through the KCCRB Office or Regional Team Coordinators.*

Rationale: In a mass-trauma disaster or terrorist event, survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. The local, regional, state or national entity in charge of a large-scale response will provide Informational briefings at select times. KCCRB staff, KCCRB Disaster Coordinator and KCCRT Response Coordinators are designated to work with officials and may consult officials about the need to do so and offer to be present during briefings to provide support as needed. They may offer suggestions to officials about:

- Appropriate language/terminology
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

Crime Victim Assistance

Protocol: *There are two types of situations that KCCRT/Disaster Outreach Personnel may need to provide crime victim assistance:*

- *be deployed after a local crime event*
- *in authorized response to mass-trauma disaster or terrorist event*

Rationale: Especially in a terrorist event, crime victim services are a central element of effective response. Interventions linked to the criminal justice process include:

- Providing information about the criminal justice process and the roles of the various participants in that process, provided in the primary, spoken languages;
- Facilitating access to State crime victim and other appropriate compensation programs for payment of crime-related expenses as well as other community resources; and
- Streamlining procedures for accessing services and benefits and responding to unique needs.

While no one can undo the losses and trauma of the event, sensitive and responsive recognition of victims' rights and needs throughout the criminal justice process can mitigate some of the most painful effects. When a large number of survivors have a "need to know" following a mass criminal event, an effective, centralized, and accessible system of information dissemination is appropriate. An active, working partnership between KCCRT/Disaster Outreach Personnel and crime victim assistance providers ensures that the broad range of survivor and family needs will be addressed. Cross-referral, cross training, and cross-consultation is recommended (Office for Victims of Crime, 2000).

4 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

5 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Community Outreach

Protocol: *KCCRT/Disaster Outreach Personnel provide community outreach through:*

- *Assessment*
- *Psychological first aid*
- *Collaborating with area behavioral health centers*
- *Providing KCCRB pre-approved Public Service Announcements (PSAs) to local media on normal reactions to abnormal events and hotline information*
- *Providing psycho-educational outreach to natural pre-existing groups*

Rationale: Community outreach is an essential component of a comprehensive (crisis intervention) behavioral health response to natural disasters, and acts of mass violence and terrorism. Many survivors will not seek behavioral health services actively, especially during the first several weeks. They often are not aware of the crime victim benefits available to them. When KCCRT/Disaster Outreach Personnel sensitively initiate contact with survivors, their access to behavioral health services, crime victim services, practical assistance, and information about criminal justice proceedings can be established. When cultural, economic, language, transportation, disability, or age-related barriers exist; outreach is a valuable tool for reaching special populations and at-risk survivors. Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors are gathered;
- Reaching out to survivors through the media, the Internet, and 24-hour telephone hotlines with responders who speak different languages;
- Participating in or conducting meetings for natural pre-existing groups through religious organizations, schools, employers, community centers, and other organizations; and
- Providing psycho-educational, resources, and referral information to health care and human service providers, police and fire personnel, and other local community workers.

KCCRT/Disaster Outreach Personnel form alliances with existing, trusted community entities and leaders to gain credibility and acceptance. Skilled outreach workers take the approach that they must earn the right to serve. While simple in concept, community outreach requires a range of skills. KCCRT/Disaster Outreach Personnel must be comfortable initiating conversations with survivors who have not requested their services. Good interpersonal skills and the ability to quickly establish rapport, trust, and credibility are necessary. Workers must be able to think on their feet and be diplomatic. While it is ideal for outreach workers to be from the cultural and ethnic groups they are serving, this is not always possible, especially in the first weeks after an event. Workers must be knowledgeable and respectful of the values and practices of the cultural groups impacted by the event.

Psychological Debriefing

Protocol: *KCCRT/Disaster Outreach Personnel only provide group interventions if appropriately authorized. Only those team members who have been trained to do so can facilitate group interventions. In mass-trauma disasters or terrorists' events, intervention techniques other than group interventions are most utilized.*

Rationale: The most commonly used debriefing technique is the Critical Incident Stress Debriefing (CISD) model, which was developed originally for emergency responders, who are occupationally exposed to repeat trauma and at risk for accumulated stress effects (Mitchell, 1983; Mitchell and Everly, 1993). The CISD model is intended to be implemented as a part of a larger Critical Incident Stress Management (CISM) approach.

A variety of group and individual psychological debriefing approaches have been used with a wide range of groups including emergency responders, employee groups, highly exposed survivors, community bystanders, and groups from the larger affected community. Some approaches may be referred to inaccurately as CISD, and sometimes simply referred to as "debriefing." Therefore, in all situations, it is important to carefully assess the actual techniques being implemented.

Careful attention must be paid to individual exposure levels and response to a traumatic event when considering the timing and goals of any group intervention techniques. For example, intervention techniques that strongly encourage "emotional processing" in the immediate aftermath of a trauma may not be appropriate for many individuals who are still in a state of shock or agitation (Watson, 2004).

Facilitating group approaches requires extraordinary skill and care and should not be performed without specific training. Simply knowing and following the steps of a specified debriefing model is not enough. A skilled group facilitator will carefully assess the needs of a group and will take care to assure that activities do not disrupt the normal human processes of remembering, forgetting, meeting challenges, and incorporating losses (Raphael and Wilson, 2000).

When working with disaster victims at a time of great vulnerability, it is important to assure that any psychological interventions do no harm. Ensuring that crisis intervention responders have adequate training and supervision can help assure that early intervention sets a foundation for emotional recovery for all individuals exposed to trauma.

Psycho-Education

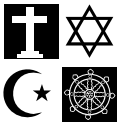
Protocol: *Psycho-education is utilized in every type of service provided by KCCRT/Disaster Outreach Personnel.*

Rationale: Psycho-education is a core component of KCCRT/Disaster Outreach Personnel response for survivors and their families, health care providers, social service workers, and providers of other community services. Information is provided about post-trauma reactions, grief and bereavement, effective coping strategies, and when to seek professional consultation. Brochures or simple handouts that describe common physical, emotional, cognitive, and behavioral trauma reactions for children and adults are widely distributed in appropriate languages. Material should be oriented specifically to the actual event and locale and adapted to each survivor group or audience to ensure age-appropriate, role-specific, and culturally relevant materials. All forms of media are used to disseminate information, so that the messages reach the largest number of people.

Validation and reassurance through psycho-educational information mitigate survivors' fear that they are "going crazy." When survivors learn their reactions are "normal" and expected following similar events, many can understand, accept, and cope with their reactions and situations. However, some survivors experience this normalization of their pain as minimizing or dismissive. Psycho-education is more successful when KCCRT/Disaster Outreach Personnel adapt their educational comments and materials to each survivor's concerns and style.

Parents and caretakers typically ask questions about how best to help children following traumatizing mass victimization. Educational presentations for parents may be offered through schools, religious organizations, and other community organizations. Psycho-education regarding children's needs addresses common questions and provides practical guidance.

Pastoral Crisis Intervention



Protocol *KCCRT/Disaster Outreach Personnel trained in Pastoral Crisis Intervention will be called on to provide services in a mass-trauma disaster or terrorist event.*

Rationale: Pastoral Crisis Intervention is the functional integration of the principles and practices of psychological crisis intervention with the principles and practices of pastoral support (Everly, 2000). KCCRB recognizes the intrinsic value of partnering with trained faith-based professionals in a mass-trauma disaster or terrorist event. Trained faith-based professionals are valuable in assisting survivors and responders in crises of faith in the aftermath of a traumatic event, in facilitating connection to survivors' own faith community and support, and in the death notification process.

Behavioral Health Consultation[6]

Protocol: *KCCRB provides services in planning and consultation. Behavioral Health professionals utilized in these services will be authorized KCCRT who are well-versed in emergency and criminal response protocols, as well as experienced in reactions to disaster, trauma, and bereavement.*

Rationale: Emergency services and law enforcement administrators make many decisions that have behavioral health implications for survivors. Government officials also make critical decisions, provide information, and make statements directly to survivors and their families and through the media. KCCRB or other behavioral health professionals can be brought into decision-making and planning teams to advise leaders regarding behavioral health issues. Leaders may seek behavioral health consultation on issues such as optimal scheduling, behavioral health support, and leave time for rescue and recovery workers; sensitive procedures for obtaining personal information and DNA samples from families for body identification; whether children should accompany families to the disaster site; rituals and memorials for honoring the dead; integrating acknowledgment of the tragedy into traditionally celebratory or recreational events; and management roles and support as affected employees return to work. When behavioral health consultation is sought, inadvertent retraumatization or unnecessary stress may be avoided (Pynoos and Nader, 1988). **To function effectively in this consulting role, behavioral health professionals must be well versed in emergency and criminal response protocols, as well as experienced in reactions to disaster, trauma, and bereavement.**

Survivors with serious psychological reactions to the traumatic event also may be members of religious groups, students at local schools, recipients of services at senior centers, community behavioral health center consumers, or members of culturally identified organizations. Service providers, clergy, principals, and teachers can be supported and educated through behavioral health consultation regarding the effects of trauma and how best to assist their constituents. In addition, impacted businesses, organizations, or government offices may seek to develop systematic behavioral health support and recovery assistance for their employees and managers (Young, et al., 1998).[i7]

6 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

7 U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

Brief Counseling Interventions[8]

Protocol: *Brief counseling goes beyond psychological first aid and crisis intervention, only authorized and qualified behavioral health professionals may provide brief counseling in a KCCRB response. These persons are either KCCRT/Disaster Outreach Personnel credentialed in counseling, local behavioral health professionals or employee assistance program credentialed personnel.*

Rationale: The therapeutic goals of brief counseling interventions involve the following:

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event
- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

Support and Therapy Groups[9]

Protocol: *KCCRT does not facilitate support or therapy groups. In the aftermath of a large-scale event, Project Recovery may provide small support group opportunities.*

Rationale: Support and therapy groups are especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance is another important function of support groups. Grief counseling is an important component of group services. It is recommended that groups be facilitated by a trained behavioral health professional, ideally with a co-facilitator, and be time-limited with expectations defined at the outset.

Support Role During Death Notification[10]

Protocol: *Only persons trained in death notification procedures may be asked by KCCRB to do a death notification in a mass-trauma disaster or terrorist event. KCCRT/Disaster Outreach Personnel may be asked to provide support.*

Rationale: KCCRT/Disaster Outreach Personnel typically do not deliver information regarding deaths but may participate on teams who accompany the person responsible for this notification. KCCRT/Disaster Outreach Personnel may provide support to the family receiving the news and, at times, to those conducting the notifications. They may also provide information to those responsible for the notification on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Death Notification Procedure

Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates. The curriculum is summarized below:

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.

2. Notify in person. Do not call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.

3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and/or trained in CPR/medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.

4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.

5. Present credentials and ask to come in.

6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.

7. Use the victim's name... "Are you the parents of _____?"

8. Inform simply and directly with warmth and compassion.

9. Do not use expressions like "expired," "passed away," or "we've lost _____."

10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "[Name] has been involved in _____ and (s)he has died." Pause again. "I am so sorry."

Adding your condolence is very important, because it expresses feelings rather than facts and invites them to express their own.

8 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

9 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

10 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

11. Continue to use the words “dead” or “died” through ongoing conversation. Continue to use the victim’s name, not “body” or “the deceased.”

12. Do not blame the victim in any way for what happened, even though he/she may have been fully or partially at fault.

13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock, have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.

14. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, and express concern. Examples: “I am so sorry.” “It’s harder than people think.” “Most people who have gone through this react similarly to what you are experiencing.” “If I were in your situation, I’d feel very _____ too.”

15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.

16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.

17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.

18. Do not speak to the media without the family’s permission.

19. If identification of the body is necessary, transport next of kin to and from the morgue, and help prepare them by giving a physical description of the morgue and telling them that [Name] will look pale because blood settles to the gravitational lowest point.

20. Do not leave survivors alone. Arrange for someone to come, and wait until they arrive before leaving.

21. When leaving, let the persons know you will check back the next day to see how they are doing and if there is anything else you can do for them.

22. Call and visit again the next day. If the family does not want you to come, spend some time on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.

23. Ask the family if they are ready to receive [Name’s] clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.

24. If there is anything positive to say about the last moments, share them now. Give assurances, such as “most people who are severely injured do not remember the direct assault and do not feel pain for some time.”

Do not say, “s(he) did not know what hit them” unless you are absolutely sure.

25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.

26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.

27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis. Do not try to carry the emotional pain all by yourself, and do not let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Serving Populations with Special Needs

Assessing the potential behavioral health needs of different groups following a terrorist event includes a review of the three elements listed below. High levels of any of these indicate a need for monitoring and possible intervention.

- Nature and severity of the event. This can be assessed several ways. One obvious way is by looking at the number of casualties and the amount of property damage that result from the event. However, the level of terror and fear spread among communities and individuals may not necessarily coincide with casualties or property damage.
- Level of exposure/proximity to the event. Terrorism affects the entire community, but it most severely affects those who experience the event directly or those who have previously been traumatized by a terrorist-related event.
- Group-specific vulnerabilities that could be aggravated by the event.

The KCCRT/Disaster Outreach Personnel should keep in mind that, during a terrorist event, the populations often categorized as "at risk" populations may not necessarily be those most in need of behavioral health services. The need will largely be determined by the specifics of the terrorist event. However, the following factors may be used as considerations when attempting to identify specific populations within a community that may be adversely affected.

- Race/ethnicity
- Refugee and immigrant status
- Age
- Gender
- Religion
- Attitudes (including mental health stigmas)
- Lifestyles and customs
- Interests
- Values
- Beliefs
- Physical disability status
- Mental/emotional disability status
- Family frameworks (e.g., single-parent, blended-family, or multiple-family households)
- Income levels
- Professions and unemployment rate
- Languages and dialects
- Education and literacy levels

Providing Services to Children and Older Adults

Interventions and services need to be designed and adapted to "fit" special populations. Recognizing, for example, that parents and caretakers are primary contributors to a child's recovery from trauma and bereavements, KCCRT/Disaster Outreach Personnel should incorporate interventions with these significant adults into a plan for children. Similarly, those intervening with elderly survivors should modify the content and format of psychoeducational materials as well as the delivery strategy for services. KCCRT/Disaster Outreach Personnel should be knowledgeable about developmental differences in cognitive and emotional processing and in the daily routines that need to be reestablished.[11]

The following charts provide practical suggestions for providing services to children and older adults.

Table 4. Reactions to Trauma and Suggestions for Intervention[12]

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1-5	Clinging to parents or familiar adults Helplessness and passive behavior Resumption of bed wetting or thumb sucking	♦ Loss of appetite ♦ Stomach aches ♦ Nausea ♦ Sleep problems, nightmares ♦ Speech difficulties ♦ Tics	♦ Anxiety ♦ Generalized fear ♦ Irritability ♦ Angry outbursts ♦ Sadness ♦ Withdrawal	♦ Give verbal reassurance and physical comfort ♦ Clarify misconceptions repeatedly ♦ Provide comforting bedtime routines ♦ Help with labels for emotions ♦ Avoid unnecessary separations ♦ Permit child to sleep in parents' room

11 DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

12 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
	Fears of the dark Avoidance of sleeping alone Increased crying			temporarily ♦ Demystify reminders ♦ Encourage expression regarding losses (deaths, pets, toys) ♦ Monitor media exposure ♦ Encourage expression through play
6-11	Decline in school performance School avoidance Aggressive behavior at home or school Hyperactive or silly behavior Whining, clinging, acting like a younger child Increased competition with younger siblings for parents' attention Traumatic play and reenactments	♦ Change in appetite ♦ Headaches ♦ Stomach aches ♦ Sleep disturbance, nightmares ♦ Somatic complaints	♦ Fear of feelings ♦ Withdrawal from friends, familiar activities ♦ Reminders triggering fears ♦ Angry outbursts ♦ Preoccupation with crime, criminals, safety, and death ♦ Self blame ♦ Guilt	♦ Give additional attention and consideration ♦ Relax expectations of performance at home and at school temporarily ♦ Set gentle but firm limits for acting out behavior ♦ Provide structured but undemanding home chores and rehabilitation activities ♦ Encourage verbal and play expression of thoughts and feelings ♦ Listen to child's repeated retelling of traumatic event ♦ Clarify child's distortions and misconceptions ♦ Identify and assist with reminders ♦ Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, identifying at-risk children
12-18	Decline in academic performance Rebellion at home or school Decline in previous responsible behavior Agitation or decrease in energy level, apathy Delinquent behavior Risk-taking behavior Social withdrawal Abrupt shift in relationships	♦ Appetite changes ♦ Headaches ♦ Gastrointestinal problems ♦ Skin eruptions ♦ Complaints of vague aches and pains ♦ Sleep disorders	♦ Loss of interest in peer social activities, hobbies, recreation ♦ Sadness or depression ♦ Anxiety and fearfulness about safety ♦ Resistance to authority ♦ Feelings of inadequacy and helplessness ♦ Guilt, self-blame, shame and self-consciousness ♦ Desire for revenge	♦ Give additional attention and consideration ♦ Relax expectations of performance at home and school temporarily ♦ Encourage discussion of experiences of trauma with peers, significant adults ♦ Avoid insistence on discussion of feelings with parents ♦ Address impulse to recklessness ♦ Link behavior and feelings to event ♦ Encourage physical activities ♦ Encourage resumption of social activities, athletics, clubs, etc. ♦ Encourage participation in community activities and school events ♦ Develop school programs for peer support, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens
Adults	Sleep problems Avoidance of reminders Excessive activity level	♦ Nausea ♦ Headaches ♦ Fatigue, exhaustion	♦ Shock, disorientation, and numbness ♦ Depression, sadness	♦ Protect, direct, and connect ♦ Ensure access to emergency medical services ♦ Provide supportive listening and

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
	Protectiveness toward loved ones Crying easily Angry outbursts Increased conflicts with family Hyper-vigilance Isolation, withdrawal, shutting down	♦ Gastrointestinal distress ♦ Appetite changes ♦ Somatic complaints ♦ Worsening of chronic conditions	sadness ♦ Grief ♦ Irritability, anger ♦ Anxiety, fear ♦ Despair, hopelessness ♦ Guilt, self-doubt ♦ Mood swings	opportunity to talk about experience and losses ♦ Provide frequent rescue and recovery updates and resources for questions ♦ Assist with prioritizing and problem-solving ♦ Assist family to facilitate communication and effective functioning ♦ Provide information on traumatic stress and coping, children's reactions, and tips for families ♦ Provide information on criminal justice procedures, roles of primary responder groups ♦ Provide crime victim services ♦ Assess and refer when indicated ♦ Provide information on referral resources
Older Adults	Withdrawal and isolation Reluctance to leave home Mobility limitations Relocation adjustment problems	♦ Worsening of chronic illnesses ♦ Sleep disorders ♦ Memory problems ♦ Somatic symptoms ♦ More susceptible to hypo and hyperthermia ♦ Physical and sensory limitations (sight, hearing) interfere with recovery	♦ Depression ♦ Despair about losses ♦ Apathy ♦ Confusion, disorientation ♦ Suspicion ♦ Agitation, anger ♦ Fears of institutionalization ♦ Anxiety with unfamiliar surroundings ♦ Embarrassment about receiving "hand outs"	♦ Provide strong and persistent verbal reassurance ♦ Provide orienting information ♦ Ensure physical needs are addressed (water, food, warmth) ♦ Use multiple assessment methods as problems may be underreported ♦ Assist with reconnecting with family and support systems ♦ Assist in obtaining medical and financial assistance ♦ Encourage discussion of traumatic experience, losses, and expression of emotions ♦ Provide crime victim assistance

Approaches for Stress Prevention and Management for First Responders

Emergency workers—police, rescue squads, firefighters—are often the first ones on the scene and the last ones out. Long hours, harsh working conditions, and a close-up view of death and destruction leave them vulnerable to intense trauma reactions.

Table 6. Approaches for Stress Prevention and Management for First Responders[13]

Dimension	♦ Immediate Response	♦ Longer Term Response
Management of workload	♦ Clarifying with immediate on-site supervisor regarding task priority levels and work plan ♦ Recognizing that "not having enough to do" or "waiting" is an expected part of crisis mental health response ♦ Delegating existing "regular" workload so that workers are not attempting disaster response and their usual job	♦ Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") ♦ Conducting periodic review of program goals and activities to meet stated goals ♦ Conducting periodic review to determine feasibility of program scope with the human resources available
Balanced lifestyle	♦ Ensuring nutritional eating and hydration; avoiding excessive junk food, caffeine, alcohol, or tobacco ♦ Getting adequate sleep and rest, especially on longer assignments ♦ Engaging in physical exercise and gentle muscle stretching when possible ♦ Maintaining contact and connection with primary social support	♦ Maintaining family and social connections away from program ♦ Maintaining (or beginning) exercise, recreational activities, hobbies, or spiritual pursuits ♦ Pursuing healthy nutritional habits ♦ Discouraging overinvestment in work
Stress reduction strategies	♦ Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) ♦ Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) ♦ Talking about emotions and reactions with coworkers during appropriate times	♦ Using cognitive strategies (e.g., constructive self-talk, restructuring distortions) ♦ Exploring relaxation techniques (e.g., yoga, meditation, guided imagery) ♦ Pacing self between low- and high-stress activities, and between providing services alone and with support ♦ Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
Self-Awareness	♦ Recognizing and heeding early warning signs for stress reactions ♦ Accepting that one may not be able to self-assess problematic stress reactions ♦ Over-identifying with or feeling overwhelmed by survivors' and families' grief and trauma may result in avoiding discussing painful subjects ♦ Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	♦ Exploring motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) ♦ Understanding when "helping" is not being helpful ♦ Understanding differences between professional helping relationships and friendships ♦ Examining personal prejudices and cultural stereotypes ♦ Recognizing discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety, which interferes with the capacity to "be" with clients ♦ Recognizing over-identification with survivors' frustration, anger, anguish, and hopelessness, resulting in loss of perspective and role ♦ Recognizing when own disaster experience or personal history interferes with effectiveness ♦ Being involved in opportunities for self-exploration, and addressing emotions evoked by disaster work

13 DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Emergency Risk Communication

Working with Media Spokespersons

Protocol: *The Kentucky Department of Military Affairs Public Information Officer (PIO) must approve all information provided to the media by KCCRB representatives. Several of the handouts utilized in disasters and responses have been previously approved.*

Rationale: When approached by media during the event, the primary role of the disaster mental is to refer the media to an appropriate spokesperson.

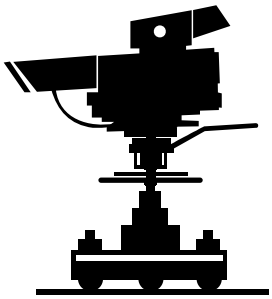
The media can be important allies in promoting disaster mental health services and events to the community in the days following the event. Acknowledging the media's role in providing and sharing information with the public, and working to keep a cooperative relationship with them, is important. This can be accomplished by referring the media to the appropriate spokespersons, and following journalistic guidelines, such as those discussed below, when providing information about disaster mental health services and events.

Do

- Refer them to your organization's spokesperson.
- Make yourself available to them if approved by your organization.
- Realize that they decide what goes in their broadcast or publication and what they tell their audience.
- Make suggestions for the most important points to cover in the story or suggestions for other people to interview.
- Make points clear, concise, and consistent.
- Acknowledge when you do not have enough information or are unclear about something.

Do not

- Ignore them.
- Give them any information without the approval of the appropriate communication officer.
- Spoon-feed them stories or headlines.
- Dictate what you think they should put in their broadcast or publication.
- Expect that what you think is news will always be considered news by the media.



Self-Care
For KCCRT/Disaster Outreach Personnel

When considering self-care during or after a terrorist event, it is important to examine two separate areas: emotional care and personal safety. Emotional care involves protecting one's own behavioral health and functioning, and personal safety refers to being aware of physical risks that one may be exposed to when involved with crisis response.

Emotional Care

Emotional care is particularly important in a terrorist situation because the KCCRT/Disaster Outreach Personnel may also be considered a survivor of the event. Few people who respond to a mass casualty event remain untouched by it.

An important tool in protecting one's emotional health during a crisis is setting personal boundaries. The boundaries that KCCRT/Disaster Outreach Personnel set will require a realistic assessment of their personal limits and what is needed to be effective in providing services to others. Keep in mind that it may be harder to maintain personal boundaries in a crisis because KCCRT/Disaster Outreach Personnel also may have endured the same event, which can make it harder to remain emotionally detached. A few examples of personal boundaries that could be set include:

- Limiting exposure to media coverage
- Setting work hours (e.g., limiting shifts to 12 hours or less)
- Referring someone to another provider if the issues that come up are beyond one's expertise

Even the most experienced KCCRT/Disaster Outreach Personnel need to be attentive to his or her own stress responses. Continual self-monitoring is an important component in managing stress and one's emotional health. The Self-Monitoring Checklist on the following pages can be used to measure stress levels following a terrorist event. Experiencing a few of the listed symptoms generally does not constitute a problem, but experiencing several symptoms from each category may indicate a need for stress reduction.

By taking care of oneself, the KCCRT/Disaster Outreach Personnel will be better able to care for the victims. Some stress reduction suggestions follow the checklist.

Self-Monitoring Checklist

Check off anything that pertains to feelings, thoughts, or behaviors in the last 24–48 hours.

Behavioral

- ❑ I am more or less active than normal.
- ❑ I am not as effective or efficient as usual.
- ❑ People do not seem to understand what I am trying to say.
- ❑ I feel irritable or angry all the time.
- ❑ I cannot seem to rest, relax, or let down.
- ❑ I am eating a lot more/less than usual.
- ❑ I have trouble sleeping/am sleeping too much.
- ❑ I cry a lot or feel like crying all the time.
- ❑ I am drinking or smoking more than I usually do.

Physical

- ❑ My heart seems to beat fast all the time.
- ❑ I have an upset stomach, nausea, or diarrhea more often than normal.
- ❑ I have been gaining/losing a lot of weight.
- ❑ I perspire more than normal or often have chills.
- ❑ I have been having headaches.
- ❑ I have sore or aching muscles.
- ❑ My eyes are more sensitive to light.
- ❑ I have lower back pain.
- ❑ I feel there is a "lump in my throat" all the time.
- ❑ I jump at loud noises or when people come up behind me.

- ❑ I sleep okay, but I am still tired.
- ❑ I cannot get rid of this cold/I feel I am coming down with the flu.
- ❑ My allergies, asthma, arthritis, or other chronic health condition(s) have been bothering me more than usual.

Psychological/Emotional

- ❑ I have been on a natural high/an adrenaline rush for days.
- ❑ I feel anxious or fearful often.
- ❑ I can't keep my mind on my work.
- ❑ I feel sad, moody, or depressed.
- ❑ I have been having disturbing dreams.
- ❑ I feel guilty about what the survivors are going through.
- ❑ I feel overwhelmed, helpless, or hopeless.
- ❑ I feel isolated, lost, or alone.
- ❑ No one seems to understand or appreciate me.

Cognitive

- ❑ I am having trouble remembering things.
- ❑ I get confused easily.
- ❑ I cannot figure things out as quickly as I usually do.
- ❑ I keep making mistakes or cannot make decisions well.
- ❑ I have trouble concentrating.
- ❑ I cannot quit thinking about the disaster or incident.

Social

- ❑ I do not want to be around people.
- ❑ I do not want to listen to people.
- ❑ Trying to work with the group seems like a waste.
- ❑ I just do not like to ask for help.
- ❑ People seem so slow or unresponsive. [14]

Spiritual

- ❑ My level of faith has changed.
- ❑ My interest in my belief system has changed.
- ❑ I feel disconnected.
- ❑ I feel hopeless.
- ❑ My life seems out of balance.

Some Things One Can Do to Reduce Stress and Renew Energy

- ♦ Take a walk or stretch.
- ♦ Stop and breathe deeply for a few moments.
- ♦ Talk to a trusted friend about your situation.
- ♦ Eat nutritious foods (e.g., lean protein, whole grains, fruits and vegetables) and avoid sugar, caffeine, and alcohol.
- ♦ Take a hot bath.
- ♦ Read a humorous or interesting book on a topic completely unrelated to what you are dealing with.
- ♦ Sit in a dark room for a few minutes to help relieve headaches.
- ♦ Get to sleep early, if possible.
- ♦ Be patient with yourself.

14 Carter, N.C. (Draft, 2001). Stress management handbook for disaster response and crisis response personnel. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- Ask people who have been through a similar experience how they handle their stress.
- Get a friend to partner with you for stress monitoring and reduction.
- If you feel lonely or isolated, ask someone to go to dinner or a movie.
- Meditate.
- Exercise.
- Spend some time with friends, family, and/or pets.
- Try to stick to your morning and/or evening routines as much as possible.
- See if shifts can be rotated with a colleague so that neither person is doing high-stress work day after day.

Personal Safety

KCCRB will take all necessary steps to plan for the safety of all KCCRT/Disaster Outreach Personnel.

In order to ensure personal safety when doing community outreach, reporting to staging areas or other mass service sites, Personnel will be given a deployment briefing to include:

- deployment briefing site
- all known hazards and personal protection needs (ie. Tetanus shots or pre-deployment prophylaxis)
- appropriate attire
- needed supplies
- accountability system
- designated 2-way radio and a local map
- schedule, team assignment and reporting (outreach will always be conducted in teams)
- an orientation to what they will see and experience

It is important to keep safety in mind at all times and to help other team members stay safe. It is also crucial to trust one's instincts. Ways to promote safety include:

- Carrying a personal cell phone
- Determining the safety of an area before going there
- Monitoring the safety of the environment for possible safety changes
- Dressing appropriately (i.e., KCCRT/Disaster Outreach Personnel may need hard toed shoes, dressing for the conditions)
- Checking in with friends and family at pre-agreed time intervals over the course of the assignment
- Assessing the environment (i.e., being alert for unusual or dangerous activity/persons, honoring any request to leave)
- Determining with coordinators and team members before going out into the field what situations should be avoided

DUTIES OF THE KCCRT/DISASTER OUTREACH PERSONNEL

Job Duties

Focus is on the primary, secondary and tertiary victims who need support, psychoeducation, and perhaps some human services, but are not prime candidates for immediate treatment. Primary tasks include:

- Provide information and education on reactions to disasters, what survivors can expect to feel, what survivors can anticipate, and how survivors can set priorities and make plans to meet their immediate needs
- Conduct outreach in the community to determine the extent of the disaster and whether there are people or groups in the community that need assistance
- Practice supportive, or active, listening with survivors and their families
- Validate survivors' reactions and resilience stories, and affirm that their feelings are normal
- Connect survivors with their families
- Provide referrals to other social services, as appropriate
- Refer disaster survivors to other resources within the project and within the community

What Can a KCCRT/Disaster Outreach Personnel NOT Do?

In the role of KCCRT/Disaster Outreach Personnel, they cannot diagnose mental illness or provide medical services, psychological therapy, or clinical advice of any kind. Due to the range of reactions to a mass-trauma or terrorist attack, it is critical that the KCCRT/Disaster Outreach Personnel refer the victim/survivor to a clinician when in need of further evaluation or treatment.

Services and Interventions

This section describes services and interventions. These include community outreach and psychoeducation.

Community Outreach

Community outreach is an essential component of a comprehensive behavioral health response to acts of mass-violence/trauma and terrorism and is the major role in disaster response. KCCRT/Disaster Outreach Personnel need to consider the nature of the event and its impact, and develop a flexible plan for community outreach.

Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors and family members through the media and the Internet, and maintaining 24-hour telephone hotlines that are staffed with people who speak the languages spoken in the communities being served (providing services via hotlines usually requires additional training)
- Participating in or conducting meetings for preexisting groups through churches, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers
- Planning activities that improve communication and understanding within communities and between cultural groups—such as cross-cultural dialogues, life skills workshops, and multicultural outreach teams

Community outreach requires:

- Ability to initiate conversations with those who have not requested services
- Good interpersonal skills
- Ability to quickly establish rapport, trust, and credibility
- Thinking on your feet
- A sense of diplomacy
- Knowledge and respect of values and practices of cultural groups impacted by the event

Psychoeducation

Psychoeducation for survivors, their families, health care providers, and providers of community services is a core component of behavioral health response. Information that is typically provided covers these topics:

- Typical reactions, including “normal reactions to abnormal situations”
- Grief and bereavement
- Stress management
- Effective coping strategies
- When to seek professional help

Psychoeducation may be used informally in conversation, incorporated into group presentations and as written material for widespread distribution. Brochure and handout materials are available through KCCRB. These materials provide information that is consistent with resources from the Center for Mental Health Services and were developed through Project Recovery, Kentucky’s FEMA crisis counseling and assistance grant-funded programs.

Materials are oriented specifically to the actual event and locale, and adapted for each group or population so that it is appropriate for that group. Educational presentations for parents and teachers to help them recognize children’s reactions and help them cope may be offered through schools, religious organizations, and other community events. Consider literacy levels and the need for multiple languages when distributing written materials.

Communicating Effectively With Survivors

KCCRT/Disaster Outreach Personnel’ most important tool is communication, both verbal and nonverbal. There are several major goals for communication with survivors.

- **Gather information**—Ask questions to understand the basic facts of a person’s current situation.
- **Help clarify meaning**—Ask open-ended questions to clarify the meaning of a person’s statement.
- **Provide comfort**—Listen to survivors’ stories to help them work through what has happened.
- **Assist in problem solving**—Help survivors develop solutions to the practical problems they encounter as a result of the mass-trauma or terrorist event.

Active Listening

The art of listening has three parts:

- Listening to and understanding nonverbal behavior
- Listening to and understanding verbal messages
- Listening to and understanding the person

Tips for employing good, active listening skills are below.

- **Paraphrase**—Rephrasing portions of what the survivor has said conveys understanding, interest, and empathy. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: “So you are saying that . . .” or “I have heard you say that . . .”
- **Reflect feelings**—Personnel may notice that the survivor’s tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, “You sound angry, scared, etc.; does that fit for you?” This helps the survivor identify and articulate his or her emotions.
- **Allow expression of emotions**—Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. KCCRT/Disaster Outreach Personnel help by remaining relaxed and letting the survivor know that it is okay to feel that way.
- **Use nonverbal cues**—Use of facial expressions (e.g., smiling at appropriate times), eye contact, open body language, and head nodding shows survivors that one is listening and hears what they are saying.
- **Allow for silence, if appropriate**—Silence gives the survivor time to reflect and become aware of feelings and can prompt the survivor to elaborate. Some survivors will not feel like talking much. Simply “being with” the survivor can be supportive.

KCCRT Response:
Utilizing Multi-Component Intervention Models

Models of various interventions discussed here can be found in the appendix.

Pre-Incident Education & Preparation

Timeline: Pre-Incident

There are two areas of focus for pre-incident education and preparation: team and community.

Team: The KCCRT membership requirements include basic courses that provide initial tools for providing services. It is incumbent on the team members to take courses during their membership term that will enhance their competencies in the area of crisis intervention for individuals and groups. Team Members are required to complete (30) thirty-hours of continuing education hours in each (4) four-year period. These hours may include courses approved by KCCRB that are offered through other continuing education providers. Team Members are also encouraged to audit a course previously taken due to changes in the field and in what is considered best practices in crisis intervention. Team Members are expected to be familiar with the current intervention models utilized by KCCRT. This will assist Team Members in understanding expectations and improve ability to cope with a variety of response types and the stressors associated with them.

Community: The community includes first responders, agencies, schools, businesses and communities impacted by disasters. Pre-incident education involves organizational consultation, crisis planning and preparedness, in-service training and administrative and supervisory training. Pre-incident education and preparation assists these communities in setting expectations, improving coping skills and stress management.

KCCRB offers a variety of workshops and in-service training modules to assist the communities in the planning and preparation phase. KCCRT Regional Team Coordinators and Team Leaders may submit a letter to the Training Coordinator expressing interest in presenting workshops or in-service training modules to community groups.

During or Post-Incident Interventions

Timeline: During prolonged incident response

Peer responders may be deployed to an active scene for the purpose of providing 1:1 intervention to impacted responders during a particularly difficult and prolonged incident. Only 1:1s, demobilizations (after final shift disengagement for a responder), staff consultations and possibly an informational briefing would be done on scene. Group interventions are not done.

Community or Organizational Consultation

Timeline: During or immediately after an incident

Community or organizational leaders may request consultation regarding the need for crisis intervention in the aftermath of an incident in order to provide necessary services to their members. KCCRB Staff usually provides consultations. Consultations are done for the purpose of fostering support and communications, mitigating symptoms, providing closure if possible, and referrals if necessary.

Demobilizations

Timeline: At shift disengagement when responders will not be returning to the scene. Only utilized in large-scale, prolonged incident response on events requiring over 100 personnel. Very rare intervention.

Goals of Demobilization: Assess well-being of personnel prior to scene disengagement; mitigate impact of stress; provide psychological first aid as needed; assess need for additional services, and provide one-on-one support.

Demobilization Contraindications: Not for routine events. Not for small sized events. Not for LODD. DEMOBILIZATIONS ARE RARE! Use wisely.

Crisis Management Briefing (CMB) or Informational Briefing (IB)

Timeline: Utilized anytime post-event. Four – phase group briefing.

The overall goals of a CMB or IB are to provide information and consultation, allow for psychological decompression, and stress management. The process is used to address those persons impacted by an incident.

KCCRT is sometimes called upon to provide guidance in coordinating or helping present a CMB or IB. These interventions are taught in the Group or Advanced Group Crisis Intervention course.

CMB or IB can accommodate 10-300 individuals who have experienced a common crisis. Timing should be flexible and dependent upon the situation. Requires 45 – 75 minutes for implementation.

Phase 1: Bring together a group of people who have experienced a common traumatic event. Goal: to re-establish a sense of community necessary to initiate a healing process.

Phase 2: Most authoritative source should present relevant facts of event. Goals: address rumor mill, reduce anxiety, return a sense of control to victims. Sharing the facts as they emerge can be very calming to the situation.

Phase 3: Discuss the most common reactions to the kind of traumatic event the group has just experienced.

Phase 4: Summary, questions and answers, if forum and situation allow, handouts contain stress management and coping strategies, and local resources for medical, behavioral health, and other professional services.

One-on-One Crisis Intervention and Peer Support

Timeline: Anytime during a prolonged event or post-event.

The One-on-One Crisis Intervention model used by KCCRT is the SAFER Model (see appendix). This intervention is taught in detail in the Individual Crisis Intervention and Peer Support course. This intervention model is cognitively driven to kick-start one's coping skills.

Peer Support is the provision of crisis intervention by those who walk the walk and talk the talk. Peers include individuals who share similar roles and responsibilities as the person in crisis (i.e., fire, police, ems, school, behavioral health, etc.).

One-on-one crisis intervention can be used anytime and anywhere for the purpose of symptom mitigation, assisting individual in returning to function, and to provide referrals as needed.

Defusing Group Crisis Intervention

Timeline: Post-event, within 12 hours

Defusing is a group crisis intervention to be utilized within the first 12 hours post-event. The group should be a small homogenous work group. (e.g. directly impacted persons vs. indirectly impacted.) In a large event, it is possible that two or more defusings would take place with different homogenous groups at the same time. Defusings may be repeated for ongoing events.

Defusing is utilized as part of a multi-component intervention strategy and is not intended to be a stand-alone intervention. Other interventions should be used in conjunction with any group intervention.

The Defusing Model is taught in the Group Crisis Intervention Course. Only KCCRT Members who have had training in the group crisis intervention models will be called upon to participate in a group intervention.

Psychological Debriefing Group Crisis Intervention (CISD)

Timeline: Post-event, 1-10 days; 3-4 weeks in a mass disaster

Psychological Debriefing (CISD) is a 7-phase structured small group crisis intervention used with homogenous groups. It is symptom driven, and can be event driven. The purpose of this group intervention is to mitigate distress, facilitate psychological closure or facilitate access to continued care.

Psychological Debriefing is utilized as part of a multi-component intervention strategy and is not intended to be a stand-alone intervention. Other interventions should be used in conjunction with any group intervention.

The Psychological Debriefing Model is taught in the Group or Advanced Group Crisis Intervention Course. Only KCCRT Members who have had training in the group crisis intervention models will be called upon to participate in a group intervention.

Family Support

Timeline: During a prolonged event or post-event.

Distress can be "contagious;" those who initially experience acute stress reactions often affect family members. Families of victims/survivors require support, especially when loved ones are seriously injured or killed.

Family Support Interventions may include one-on-one with family members of impacted personnel, or a group intervention with family members after a large-scale event.

Pastoral Crisis Intervention

Timeline: During a prolonged event or post-event.

Faith-based team members specifically trained to provide such services do Pastoral Crisis Intervention (PCI). The purpose of PCI is to mitigate a "crisis of faith" and use spiritual tools to assist in recovery.

The Pastoral Crisis Intervention Model is taught in the Pastoral Crisis Intervention Course.

Assessment & Triage

Timeline: Anytime during event or post-event.

KCCRB Staff, Regional Team Coordinators, or Team Leaders specifically trained in assessment and triage will determine the depth and scope of crisis intervention needs, make recommendations to incident command or supervisory staff of the population impacted and initiate appropriate crisis response services as requested. Assessment and triage includes determining how many people are impacted and to what degree (See Population Exposure Model below).

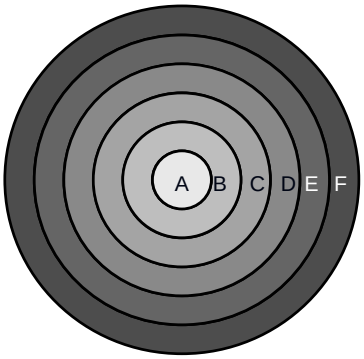
The type of population determines which team members will be deployed. For instance, if a fire department requested intervention services to assist in dealing with a fire that included child fatalities, team members who are firefighters would be deployed to provide 1:1 interventions and assist with group intervention. If a school requests services due to the death of a child, team members who are either school-based or behavioral health professionals would be deployed.

Triaging is very important to ensure that crisis intervention services identify the persons or groups that will take priority in receiving services in larger scale events.

Population Exposure Model [ii]

When providing crisis intervention in a disaster, team members must consider the levels of exposure experienced by individuals and the resulting psychological impact when assessing need for intervention. The Population Exposure Model below illustrates generalized levels of impact. This can be used as a guide for team intervention planning, however, other considerations like pre-existing issues and stressors must also be taken into consideration.

A. Dead or seriously injured; bereaved family and friends
B. High exposure to trauma, but not injured
C. Bereaved extended families and friends; residents in disaster zone; first responders and immediate service providers.
D. Caregivers and community providers: mental health providers, clergy/chaplains, emergency health care providers,
E. Government officials, groups, businesses.
F. Community at large.



Not all events and traumatic stressors are equal in their potential for psychological impact. Eight dimensions of traumatic exposure associated with post-traumatic stress are:

- Threat to life and limb;
- Severe physical injury;
- Receipt of intentional injury;
- Exposure to the grotesque;
- Violent/sudden loss of a loved one;
- Witnessing or learning of violence to a loved one;
- Learning of exposure to a noxious agent;
- Causing death or severe injury to another.

(Green, 1993)

Most of these dimensions are inherent in mass violence and terrorism. The level of community trauma is increased when there are both large numbers of victims relative to non-victims and high numbers of fatalities and serious injuries *(Tierney, 2000).*[iii]

KCCRT Regional Team Coordinators or assigned Team Leaders may use this model to assist in determining the levels of response needed. In addition, other factors should be taken into consideration, such as:

- Cultural or ethnic considerations
- Special populations

Cultural, racial, or ethnic group affiliation may promote resilience through social, family, and community support. Cultural beliefs, traditions, and rituals may provide mechanisms to understand the tragedy and more through the recovery process. [iv]

- Preoccupation with protecting loved ones
- Questioning of spiritual or religious beliefs

The organizational structure for emergency response to mass casualty criminal incidents is complex. Emergency medical services, law enforcement, search and rescue, the medical examiner's office, (county coroner), emergency management, the criminal justice system and government authorities have key roles and responsibilities throughout the immediate response. Jurisdictions may move from the local to State to Federal levels and span various agencies. [v]

APPENDIX

Definitions

Illustration 1: Behavioral Health Response To Mass Violence & Terrorism

Illustration 2: Comparison of Mass Violence Victimization and Natural Disasters

Illustration 3: Survivor Characteristics

Common Survivor Reactions

Intervention Timing Chart

Intervention Models

Definitions

Activation KCCRB Disaster Coordinators assess the immediate need and deploy Regional Team Coordinators (RTC's) that are in and near the impacted areas. Those RTCs then put their Regional Team Members on Standby.

Behavioral Health Professional means an individual who is licensed or certified to provide mental health or substance abuse services in Kentucky. A behavioral health professional may work in a private practice or with a county, city, or state private organization or government agency.

Community A grouping of persons who are closely affiliated. Affiliation may be natural, such as neighborhoods, schools, fire service, or other existing organizations or groups or they may be "artificial" such as passengers on a plane who are affiliated by the mutual experience of a crisis or critical incident.

Continuing education hour means a minimum of fifty contact minutes of participation in an approved educational experience.

Core competency means a required unit of continuing educational content approved by the Board relating to the provision of a crisis intervention, psychological first aid, psychoeducation, and disaster mental health services by a team member.

Crisis means an event that has the potential to create significant human distress.

Crisis intervention means assistance to victims, survivors, first responders, and others to regain a sense of control over their immediate situation and reestablish problem-solving abilities, promoting safety and security; exploring the person's experience with the crisis or disaster; identifying current priority needs, assessing functioning and coping skills; providing reassurance, normalization, psychoeducation, practical assistance, and making referrals as needed. An underlying assumption is that the distress and coping difficulties are due to the suddenness, horror and catastrophic nature of the event.

Crisis response service means the delivery of crisis intervention, psychological first aid, psychoeducation, and disaster mental health services.

Critical Incident Stress Management (CISM) is a comprehensive, systematic, & multi-component approach to the management of traumatic stress.

Deployment This is when Team Members are sent to a site as part of a Team in order to provide intervention services. Only KCCRB staff and RTCs can deploy Team Members. Self-deployment is strictly forbidden.

Disaster means an occurrence, regardless of cause, such as a hurricane, tornado, flood, earthquake, explosion, hazardous materials accident, war, transportation accident, mass shooting, fire, famine, or epidemic that causes: (a) Human suffering; or (b) Creates collective human need that requires outside assistance to alleviate; or (c) Means an incident or situation declared as such by executive order of the Governor, or President of the United States, pursuant to federal law; and (d) Is of sufficient severity and magnitude to warrant disaster assistance to supplement the resources of States, local governments and disaster relief organizations in alleviating damage, loss, hardship and suffering.

Disaster Mental Health means the rapid mobilization of KCCRT/Disaster Outreach Personnel to provide post-disaster mental health designed to support resilience and recovery. Psychological tasks of recovery include: acceptance of the disaster and losses, identification and expression of emotions, regaining a sense of control and resumption of age-appropriate roles and activities. Trained behavioral health professionals, peer professionals and KCCRT/Disaster Outreach Personnel provide disaster mental health.

Disaster Outreach Personnel means: behavioral health professionals, peer professionals or para-professionals; trained victim advocate; adults from communities who possess cultural, multilingual skills or life experiences necessary to identify and communicate with survivors and victims; or support personnel necessary in providing disaster and crisis intervention services; and approved by the Board to provide disaster mental health services and trained to alleviate the pain and distress of affected groups and individuals during a response effort, but are not a licensed or credentialed mental health provider.

Human-caused disaster means a deliberate, potentially avoidable incident that is perceived as preventable and caused by the decision or action of an individual or group resulting in one or more of the following: (a) Severe property damage; (b) Deaths; or (c) Mass casualties; or (d) Horror or catastrophic nature of the event.

Kentucky Community Crisis Response Team means a voluntary group, under the authority of the Board, separate from the Kentucky Community Crisis Response Board, of trained and approved team members who provide a specific crisis response service when requested by the Executive Director or staff.

Lead agency means the Kentucky Community Crisis Response Board coordinates and ensures disaster mental health services in accordance with the Kentucky Disaster plan.

Peer professional means an individual who is trained in emergency services, law enforcement, rescue and recovery, clergy, public health, hospital, school personnel and other individuals approved by the Board who are trained to alleviate the pain and distress of affected groups and individuals during a response effort, but is not a licensed or credentialed mental health provider who: (a) Is licensed, certified, or credentialed as required by their respective field; and (b) Adheres to a code of conduct established by their respective field or organization.

Provider means an organization or individual approved by the Board to provide comprehensive crisis response intervention training and continuing education.

Psychoeducation means supporting survivors, victims, first responders and others by providing information about post-trauma reactions, including normal reactions to abnormal situations; grief and bereavement, stress management and effective copying strategies and indications of when to seek professional help.

Psychological First Aid means the application of three basic concepts of: protect, direct and connect. Includes: addressing immediate physical needs; comforting and consoling survivors, victims, first responders and others; providing concrete information about what will happen next, listening to and validating feelings; linking survivors to support systems; normalizing stress reactions to trauma and sudden loss; reinforcing positive coping skills; facilitating telling their story and supporting reality-based practical tasks.

Psychosocial Distress means one's reaction to an event that is: (a) Outside the person's usual realm of psychological and social experience; (b) Potentially overwhelming, and (c) Markedly distressing for an individual.

Recognized community crisis response team means a team that: (a) Meets crisis response team criteria established by the Board; (b) Responds to community crisis and disasters when requested by the Executive Director; or designee, and (c) Coordinates response activities with the Kentucky Community Crisis Response Board.

Regional Team Coordinator (RTC) means an approved team member delegated by the Executive Director to support the Kentucky Community Crisis Response Team in one or more of the following capacities:

(a) Serves as a local and regional contact for planning, exercising and responding to a crisis or disaster in coordination with: The Kentucky Division of Emergency Management; The Department of Public Health; or Another organization identified by the Board;

(b) Serves as the liaison for communicating the needs of the regional crisis response team to the Kentucky Community Crisis Response Board on a regular basis; Facilitates regional team meetings on a regular basis; Completes necessary written regional reports; and Completes other duties delegated by the Executive Director or staff.

Stand-by means being prepared to respond for a particular crisis or disaster if deployed. RTCs and Team Members are put on *standby* when a need for deployment of teams is anticipated. Either the RTCs or the KCCRB staff will contact Team Members to inquire if the Team Members are available to be deployed, if necessary. If Team Members agree to be on *standby*, it means they are prepared and willing to be deployed.

Stand-down means the Stand-by command has been cancelled.

Survivor means an individual who has experienced the impact of a crisis, disaster or terrorist event either indirectly or directly.

Team Debriefing This very short process is intended to assist Team Members in: assessing how the interventions went and identifying personal stress management strategy. It is important for the welfare of the Team to have a Team Debriefing prior to leaving an intervention site. Every Team Member is expected to participate in this short debriefing.

Team Leader means an approved team member designated by the Executive Director or staff to provide one or more of the following duties during a crisis response: (a) Coordination of other crisis response team members; (b) Completing and submitting written reports; and Completing other duties delegated by the Executive Director or staff.

Team Member means an individual approved by the Board who has: (a) Successfully completed the team membership application process; (b) Returned a signed team membership agreement and other documentation to the Executive Director or designee prior to participating in an authorized crisis response; and (c) Possesses a current team membership photo identification badge.

Team membership agreement means a document approved by the Board that delineates the requirements and guidelines for crisis response team membership.

Victim means an individual who has experienced the immediate impact of a crisis, disaster or terrorist event.

Illustration 1: BEHAVIORAL HEALTH RESPONSE TO MASS VIOLENCE & TERRORISM

Behavioral Health Roles in Crisis Response

- Behavioral health consultation
- Liaison with key agencies
- Psycho-education through media
- Behavioral health services with survivors, families
- Behavioral health services with responders
- Stress management support

Key Concepts

- Normal reactions to an abnormal situation
- Avoid "mental health" terms and labels
- Assume competence and capability
- All who witness are affected
- Respect differences in coping
- First, do no harm
- Assistance is practical and flexible
- Focus on strengths and potential
- Encourage user of support network
- Tailor for active, community fit
- Be innovative in helping

On-Scene Interventions

- Direct to medical care, safety, shelter
- Protect from trauma, media, onlookers
- Connect to family, information, comfort

(Myers and Wee, 2003)

Immediate Interventions

- Rapid assessment and triage
- Psychological first-aid
- Crisis intervention
- Crime victim assistance
- Psycho-education
- Informational briefings
- Community outreach
- Participation in death notifications
- Behavioral health consultation
- Debriefing and community meetings
- Information and referral

Psychological First-Aid

- Provide comfort, empathy, an "ear"
- Address physical needs
- Provide concrete information about what will happen next
- Link to support systems
- Reinforce coping strengths

Crisis Intervention

- Promote safety and security
- Gently explore trauma experience
- Identify priority needs and solutions
- Assess functioning and coping
- Provide: Reassurance,
  Psycho-education, Practical assistance

Crime Victim Assistance

- Protect victims' rights
- Ensure control over media contacts
- Provide criminal justice information
- Facilitate access to compensation
- Streamline bureaucratic procedures

Community Outreach

- Initiate contact at gathering sites
- Set up 24-hour telephone hotlines
- Outreach to survivors through media, Internet
- Educate service providers
- Use bilingual and bicultural workers

Participation in Death Notification

Responsible notifier:

- Obtains critical information
- Notifies next-of-kin directly, simply, in person
- Expects intense reactions
- Provides practical assistance
- Behavioral health participates on team, provides support and information

Brief Trauma Intervention

- Factual information
- Thoughts during event
- Reactions and feelings
- Psycho-education
- Problem-solving and action [vi]

Illustration 2: Comparison of Mass Violence Victimization and Natural Disasters [vii]

DIMENSION	Mass Violent Victimization	Natural Disasters
Examples	♦ ♦ Mass Riots ♦ Terrorists Bomb ♦ Bioterrorism ♦ Hostage Taking ♦ Arson ♦ Mass Shooting ♦ Aircraft hijacking	♦ ♦ Hurricane ♦ Earthquake ♦ Tornado ♦ Flood ♦ Volcanic Eruption ♦ Wildfire ♦ Drought
Causation	♦ Include evil human intent; deliberate sociopolitical act, human cruelty, Revenge, hate or bias against a group, mental illness.	♦ Is an act of nature; severity of impact may result from interaction between natural forces and human error or actions.
Appraisal of Event	♦ Event seems incomprehensible, senseless. ♦ Some view as uncontrollable and unpredictable, others view as preventable. ♦ Social order has been violated.	♦ Expectations defined by disaster type. ♦ Awe expressed about power and destruction of nature. ♦ Disasters with warnings increase sense of predictability and controllability. ♦ Recurring disasters pose ongoing threat.
Psychological Impact	♦ Life threat, mass casualties, exposure to trauma, and prolonged recovery effort result in significant physical and emotional effects. ♦ There are higher rates of Post-Traumatic Stress Disorder (PTSD), depression, anxiety and traumatic bereavement that can last for a longer period of time.	♦ Property loss and damage and primary impacts, so reactions relate to losses, relocation, financial stress, and daily hassles. ♦ Disaster traumatic stress typically resolves over 18 months, with lower rates of diagnosable disorders unless high number of fatalities and serious injuries.
Subjective Experience	♦ Victims are suddenly caught unaware in a dangerous, life-threatening situation. May experience terror, fear, horror, helplessness, and sense of betrayal and violation. ♦ Resulting distrust, fear of people, or being 'out in the world' may cause withdrawal and isolation. ♦ Outrage, blaming the individual or group responsible, desire for revenge, and demand for justice are common.	♦ Separation from family members, evacuation, lack of warning, life threat, trauma, and loss of irreplaceable property and homes contribute to disaster stress reactions. ♦ Anger and blame expressed toward agencies and individuals responsible for prevention, mitigation, and disaster relief.
World View/ Basic Assumptions	♦ Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just, and orderly. ♦ Survivors confronted with the reality that evil things can happen to good people. ♦ People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.	♦ Spiritual beliefs may be shaken (e.g. "How could God cause this destruction?") ♦ Loss of security in "terra firma" that the earth is "solid" and dependable. ♦ People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.

DIMENSION	Mass Violent Victimization	Natural Disasters
Stigmatization of Victims	♦ Some victims may come to feel humiliation, responsibility for others' deaths, survivor guilt, self-blame, and unworthy of assistance, thus assigning stigma to themselves. ♦ The larger community, associates, friends and even family may distance themselves to avoid confronting the idea that crime victimization can happen to anyone. ♦ Well-meaning loved ones may urge victims and bereaved to "move on," causing them to feel rejected and wrong for continuing to suffer. ♦ Hate crimes reinforce the discrimination and stigma that targeted groups already experience.	♦ Disasters tend to have greater impact on people with fewer economic resources due to living in lower-cost, structurally vulnerable residences in higher-risk areas. ♦ Survivors from cultural, racial, and ethnic groups, single parent families, people with disabilities; and the elderly on fixed incomes experience greater barriers to recovery causing double jeopardy and potential stigma.
Phases of Response and Reconstruction	♦ Impact ♦ Outcry ♦ Disbelief, shock, and denial ♦ Interaction with criminal justice system	♦ Warning, threat ♦ Impact ♦ Rescue and heroism ♦ Honeymoon

	♦ Working-through process ♦ Coming to terms with realities and losses ♦ Reconstruction	♦ Interaction with disaster relief and recovery ♦ Disillusionment ♦ Coming to terms with realities and losses ♦ Reconstruction
Media	♦ The media shows more interest in events of greater horror and psychological impact. ♦ Excessive and repeated media exposure puts people at risk for secondary traumatization. ♦ Risk of violations of privacy.	♦ Short-term media interest fosters sense in community that "the rest of the world has moved on." ♦ Media coverage can result in violations of privacy; there is a need to protect children, victims, and families from traumatizing exposure.
Secondary Injury	♦ Victims' needs may conflict with necessary steps in the criminal justice process. ♦ Steps required to obtain crime victim compensation and benefits can seem confusing, frustrating, bureaucratic, and dehumanizing and trigger feelings of helplessness. ♦ Bias-crime victims may suffer prejudice and blame. ♦ Victims may feel that the remedy or punishment is inadequate in comparison to the crime and their losses.	♦ Disaster relief and assistance agencies and bureaucratic procedures can be seen as inefficient, fraught with hassles, impersonal. ♦ Disillusionment can set in when the gap between losses, needs, and available resources is realized. ♦ Victims rarely feel that they have been "made whole" through relief efforts.

Table 1: U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004. Page 9-10.

Illustration 3: Survivor Characteristics [viii]

SURVIVOR GROUPS' CHARACTERISTICS	RESILIENCY FACTORS
♦ Prior or pre-existing mental health or substance abuse problems ♦ Prior traumatization or unresolved losses ♦ Female gender ♦ Low socioeconomic status, low education ♦ Family instability, conflict, single-parent household ♦ Perceived or real lack of social support, isolation ♦ Overuse of coping strategies such as avoidance and blaming self or others	♦ Relative mental health, absence of history of diagnosable psychiatric problems ♦ Capacity to tolerate emotions and cope flexibly with symptoms associated with trauma and bereavement ♦ Self-perception of having ability to cope and control outcomes ♦ Higher socioeconomic status, higher education level ♦ Immediate and extended family providing practical, emotional, and financial support ♦ Effective use of social support systems

Common Survivor Reactions [ix]

Physical Reactions Can Include:

- Faintness, dizziness
- Hot or cold sensations in body
- Tightness in throat, stomach, or chest
- Agitation, nervousness, hyper-arousal
- Fatigue and exhaustion
- Gastrointestinal distress and nausea
- Appetite decrease or increase
- Headaches
- Exacerbation of pre-existing health conditions

Behavioral Reactions Can Include:

- Sleep disturbance and nightmares
- Jumpiness, easily startled
- Hyper-vigilance, scanning for danger
- Crying and tearfulness for no apparent reason
- Conflicts with family and coworkers
- Avoidance of reminders of trauma
- Inability to express feelings
- Isolation or withdrawal from others
- Increased use of alcohol or drugs
- Obsessive self-criticism and self-doubts

Emotional Reactions Can Include:

- Shock, disbelief
- Anxiety, fear, worry about safety
- Numbness
- Sadness, grief
- Longing and pining for the deceased
- Helplessness, powerlessness, and vulnerability
- Disassocation (disconnected, dream-like)
- Anger, rage, desire for revenge
- Irritability, short temper
- Hopelessness and despair
- Blame of self and/or others
- Survivor guilt
- Unpredictable mood swings
- Re-experiencing pain associated with previous trauma

Cognitive Reactions Can Include:

- Confusion and disorientation
- Poor concentration and memory problems
- Impaired thinking and decision making
- Complete or partial amnesia
- Repeated flashbacks, intrusive thoughts and images

Intervention Timing Chart

INTERVENTION	TIMING	ACTIVATION	GOAL
Pre-Crisis Education & Preparation	Pre-Crisis Phase	Crisis Anticipation	Set expectations. Improve coping. Stress management.
Demobilizations & staff consultation (rescuers)	Shift disengagement	Event driven	To inform and consult, allow psychological decompression. Stress management.
Crisis Management Briefing (CMB), (civilians, schools, business)	Anytime post-crisis	Event driven	To inform and consult, allow psychological decompression. Stress management.
Defusing	Post-crisis, (within 12 hours)	Usually symptom driven	Symptom mitigation. Possible closure. Triage.
Critical Incident Stress Debriefing (CISD)	Post-crisis (1-10 days; 3-4 week mass disaster)	Usually symptom driven. Can be event driven.	Facilitate psychological closure. Symptom mitigation. Triage.
Individual Crisis Intervention 1:1	Anytime, Anywhere	Symptom driven	Symptom mitigation. Return to function, if possible. Referral, if needed.
Family Support	Anytime	Either symptom driven or event driven	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.
Community Consultation	Anytime	Either symptom driven or event driven	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.
Organizational Consultation	Anytime	Either symptom driven or event driven	Foster support & communications. Symptom mitigation. Closure, if possible. Referral, if needed.
Pastoral Crisis Intervention	Anytime	Usually symptom driven	To mitigate a "crisis of faith" and use spiritual tools to assist in recovery.
Follow-Up/Referral	Anytime	Usually symptom driven	Assess mental status. Access higher level of care, if needed.

SAFE-R MODEL

(For brief 1:1 intervention)

S Stabilize situation
- a. Assess mental status rapidly
- b. Reduce stimuli; protect from stress
- c. Communicate clearly

A Acknowledgment of crisis
- a. Establish rapport; sense of safety
- b. Encourage safe ventilation
- c. Person describes what happened & their own reactions

F Facilitate understanding
- a. Explain normal reactions to abnormal events
- b. Discuss problem-solving options

E Encourage adaptive coping
- a. Teach basic stress/crisis mgt.
- b. Develop plan; short term goals

R Restoration
- a. Restore to functioning
- b. Refer for continued care (if needed)
- c. Refer to support resources

Group Crisis Interventions

Guidelines:

- *You do not have to talk during the intervention, but if you do what you may say may help reassure and support your colleagues.*
- *This meeting is strictly confidential. No notes will be taken and no records will be made. It is important that we make a pact of trust with everyone here that no one will disclose any information about anyone or anything said during the session.*
- *No breaks are taken during the process. If you need to use the facilities, please attend to your personal needs but then return to the group.*
- *No one talks for another. You may only comment about your own thoughts, feelings, or reactions.*
- *You do not need to say anything that may legally incriminate you, or offer information that may be necessary for any investigation or litigation.*
- *No pagers are to be on and the company (or at least those participating) is to be out of service.*
- *No one has rank during the process. Everyone is equal.*
- *This is NOT a critique of operations. We are not here to place blame.*
- *The KCCRT Team is NOT part of any investigating agency. We are only interested in your welfare.*
- *Look around the room. If someone is here that should not be here, please let us know before we begin. These include press, and any others not directly involved in the incident. (Will need to be tailored to each incident.)*
- *Feel free to ask questions.*

Defusing

(Post crisis: 1-10 days; 3-4 wks. Mass disaster)

Introduction

Facilitator
State Purpose
Motivate
Set Rules
Confidentiality
Not investigative
Finish the Process
State Goals
Describe Process
Offer Additional Support

Exploration

Ask personnel to describe what just happened
Minimal clarifying questions
Experiences and reactions

Information

Accept/Summarize their exploration
Normalize experiences and/or reactions
Teach multiple stress survival skills
Diet/Family life
Recreation
Other _____
Assess need for more help.
Reassure as necessary.

Group Crisis Intervention

(Post crisis: 1-10 days; 3-4 wks. Mass disaster)

1. Introduction
· Self/team members
· Lessens impact
· Eat/sleep/work better
· Not a critique
· No notes/recording
· Confidential
· Only asked to speak once
· Questions as you wish
· Speak only for self
· No breaks
· Leave & return quietly
· Everyone belong here
· No food/drink
· Team will be here when done

2. Facts
· Who are you?
· What was your role?

3. Thoughts
· Your 1st thought?
· When did you 1st realize you were thinking about the incident?

4. Reaction
· Identify worst part of incident for you

5. Symptoms
· Emotional
· Behavioral
· Thinking
· Physical

6. Teaching
· Natural reaction to abnormal event
· Don't fight it
· Give time
· Don't withdraw from family
· Seek support
· Help is available

7. Re-Entry
· Final assurance
· Answer questions
· Thank them
· Plan of action

Line-of-Duty Death

· Two Group Crisis Interventions - 1 on the day of death and 2nd 3-7 days after the funeral

· 5 phase process on day of death - 7 phase process 3-7 days after funeral

· 1-on-1's as necessary

· Provide family /significant other support services

Day 1 LODD Group Crisis Intervention

· Shorter - approx. 45 minutes to 1 hour

· 5 phases

1. Introduction (set tone)
2. Fact (information about death)
3. Reaction (worst part at moment)
4. Teaching (Prepare group for funeral)
5. Re-entry (Let group know CISM services will be available)

A Family Group Crisis Intervention Model (Cobb & Ewing)

PHASE I – INTRODUCTION

- Introduce team members and establish ground rules
- Tell group why they have gathered, briefly mentioning the event
- Instill the need for complete confidentiality
- Describe process and what it is not (therapy or critique of incident)
- Encourage participation and mutual support. Assure them that they are not required to speak
- Introduce themselves and define their relationship to the event

PHASE II – FACT

- Provide current information regarding the event
- Review notification process – "How were you notified?" "Where were you?"
- "What role did you play?" (Optional)

PHASE III – THOUGHT

- "What were your first thoughts and/or immediate concerns?"
- Address input and communication from other family members/ friends

PHASE IV – REACTION

- "What part of this event bothers you the most?" or "As you look back over this event, what stands out as a memorable moment – one that will stay with you for a long time?"
- "If you could erase one part, without changing the outcome, which would it be?" (Optional)

PHASE V – SYMPTOMS

- List examples of common psychological, physical, emotional, behavioral or spiritual changes
- "What was it like for YOU for the first few days after the incident?"
- "What was it like for your family members or your children?" or "How is your relationship now with them?"
- "Are you having any leftover signs of distress from the incident now?"
- Normalize all reactions as needed

PHASE VI – TEACHING

- Review normal signs/ symptoms that may arise (personally and for other family members)
- Stress the self-care concept of using survival strategies (personal/ family/ children), i.e., diet, exercise, talking and being with trusted, other people
- Provide CIS information/education (handouts) or information specific to the event
- "Has anything positive come out of this situation?" (Optional)
- Reinforce the concept of "being there for others"; reassure families that this may be all that is needed for supporting a significant other during this critical time period
- Use additional teaching material specific to the event

PHASE VII – RE-ENTRY

- Introduce any new material (if appropriate) at this time
- Review educational materials and provide appropriate handouts
- Inform participants about, and encourage them to utilize, additional, local resources
- Ask participants to select a single self-care activity to do for themselves over the next week.

TEAM DEBRIEFING

(Post Intervention — Team Care)

Person who conducts Team Debriefing:
Fresh eyes, fresh ears, experienced to be team leader
Provide neutral safe place, private, post intervention

Stage 1: REVIEW
How did it go? How do you think you did? What themes emerged? What was participation level of group? Is there anything that concerns you?

Stage 2: RESPONSE
What did you say that you wish you hadn't Wish you had said? How has this intervention affected you? What was the hardest part of this for you?

Stage 3: REMIND
Is there any follow up to be done? What are you going to do to take care of yourself? What will it take to "let go" of this? Report to Team Coordinator process was done. Assign follow up assignments for your completed intervention.

FOLLOW-UP

(Post Intervention)

Team Leader or designee will follow-up with the contact person at the agency/organization.

Follow-up Process:
Contact the person who initially requested KCCRT services.
Inquire how their group is doing.
Schedule a Group Crisis Intervention if necessary.
Is anyone indicating they may need additional 1:1 intervention?

Follow-up Reporting:
Report results of follow-up to Regional Team Coordinator or KCCRB.
Results are to be noted on the Incident Team Leader Report and submitted to KCCRB.
A customer satisfaction survey will be sent to the requesting agency.

APPENDIX ENDNOTES

[i] U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004. Pgs. 34-42.

[ii] Ibid., pgs. 11-12.

[iii] Ibid., pg. 13.

[iv] Ibid., pg. 15.

[v] Ibid., pg. 6.

[vi] Ibid., overheads.

[vii] Ibid., pgs. 9-10.

[viii] Ibid., pg. 15.

[ix] Ibid., pgs. 16-17.